Oregon Title V

Maternal and Child Health Program

Five-Year Needs Assessment

Department of Human Services
Office of Family Health
Oregon Health and Science University
Child Development and Rehabilitation Center
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Oregon Title V – Five-Year Needs Assessment

The Oregon Title V Five-Year Needs Assessment was conducted jointly by the two Title V agencies. Office of Family Health is the primary Title V Agency and the Child Development and Rehabilitation Center is the Title V Children with Special Health Needs Agency. This Needs Assessment is presented in two sections. The first section is focused on the systems and programs of the Office of Family Health and public health systems. The second section is focused on the Child Development and Rehabilitation Center and systems of care for children and youth with special health needs (CYSHN). In findings and selection of priorities and goals for Title V, this information is presented together where appropriate.

1. BACKGROUND AND PROCESS

The Oregon Title V Five-Year Needs Assessment in 2000 effectively determined lead health status issues facing the MCH population at the time. State and local partners and stakeholders participated in defining the issues and the barriers and assets to addressing those issues. The 2000 assessment issues were:

- Oral Health
- Intimate Partner Violence
- Child Abuse and Neglect
- Adolescent Mental Health and Substance Use Prevention
- Early Quality Prenatal Care

These issues continue to be a high priority of Oregon's Title V program, and substantial progress been made during the last five years,. During that time, shifts in support and reorganization of state public health systems, along with at-risk populations increasingly experiencing disparities, caused grave concerns that the capacity of public health system, including the MCH system, was not keeping pace with the issues and needs in Oregon.

The timing of the 2005 Title V Five-Year Needs Assessment was an opportunity to assess the full range of capacity assets and needs necessary to address the continuing priority issues as well as emerging health issues. Public health stakeholders at the state and local level embarked on capacity assessment activities in 2004, to inform public policy leaders of the strengths and weaknesses of the system at large. The Title V program used the findings of this needs assessment process to build an assessment of the MCH systems. The synthesized findings serve as principle assessment information to be used in planning and building MCH services infrastructure to improve design and delivery of direct and population-based health services provided through state and local agencies.

Local public health agencies identified unmet needs and health issues through planning processes in 2004. Again, the timing of these plans provided the Title V program with information to conduct further discussions and assessments about these issues. The Title V health needs assessment was organized according to the priorities reported in these plans. These issues included access to health insurance, preventive health care, emotional development, mental health services, health disparities, tobacco use, and geriatrics. These

locally derived issues framed the collection of health status data and discussion of health priorities by population groups.

PROCESS

The Five-Year Needs Assessment Values, Goals and Objectives are as follows.

- ***Goal:*** Develop a plan of interventions based on the assessed strengths and needs of Oregon's women, children and families, and the health infrastructure that serves them.

- ***Purpose:*** The purpose of the needs assessment is to use findings and recommendations of a comprehensive needs assessment to strengthen the ability of the Office of Family Health and its partners to prioritize and respond to public health issues.

- ***Values:*** We value:
  - Individuals in the context of families and communities
  - Physical, psycho-social, spiritual, and emotional health
  - Evidence-based practice in program development
  - Qualitative and quantitative problem identification
  - Continual improvement for systems and services
  - Community and professional partnerships
  - Diversity and cultural competency
  - Comprehensive and coordinated care, services, and systems
  - Safe communities

- ***Project Objectives:*** To create a plan for the Office of Family Health and Oregon Title V Programs through a comprehensive community-based needs assessment

  1. Identify statewide leaders, champions and investors to support the assessment findings, recommendations, and strategic plan
  2. Compile and synthesize existing data for MCH populations to identify leading health issues and baseline monitoring information
  3. Engage local and statewide community partners and stakeholders in assessment and planning
  4. Assess health system capacity to provide adequate, accessible services
  5. Identify intervention strategies that support positive community health outcomes
  6. Utilize innovative, best and evidence-based practices for state and local implementation
  7. Develop outcome and performance measures based on identified priorities
  8. Complete a five-year strategic action plan for Office of Family Health and Title V programs and services

A Needs Assessment Leadership Group was formed to guide the process and outcomes of the assessment throughout the process. This group included the Title V Director from the Office of Family Health (OFH), CSHCN Director from the Child Development and

Rehabilitation Center (CDRC), state-level OFH managers and staff, and a representative of the Conference of Local Health Officials, MCH Committee (Leadership Roster in Appendix 1).

A process was selected to assess essential public health services capacity as well as identify the priority MCH health issues. The assessment assumes that sufficient capacity of the ten Essential Public Health Services across Oregon's public health system is necessary to adequately address any of the priority health issues for the state's maternal and child health population. (Appendix 2 Process Template).

In 2004, state and local public health stakeholders joined together to conduct capacity assessments of public health systems using the National Public Health Performance Standards (NPHPS) instruments developed by CDC and its partners. The local public health agencies appreciated the opportunity to participate, so the Title V program funded three more National Standards assessments, adding on MCH systems assessment with a modified Capacity Assessment for State Title V (CAST-5) instrument.

To determine Oregon's MCH priority health issues, information was synthesized from community assessments and public health plans conducted in 2003-04 by county Commissions on Children and Families (CCF) and county health departments. The county CCF plans are required by statute to conduct community-wide assessments and plans for services and supports for children and families. The county health departments are required by statute to submit annual plans with information about public health needs, goals, and strategies. This material provided the key information for structuring the MCH health indicators and data for priority setting.

The assessment process assumed that the findings from both capacity and health status assessments would result in information about organizational and systemic capacity to better address the priority health issues. A logic model illustrating the progression from existing health conditions towards improved health conditions, using needs assessment and planning, is in Appendix 2a.

Other relevant assessments occurred at the same time as the Title V assessments, in Early Childhood Systems Planning and in local Adolescent Health capacity assessment. These processes were conducted by OFH programs and involved OFH and county health department staff. The findings from these assessments are included in the final results of the MCH services system.

During the course of the Title V assessment activities, several challenges or obstacles interfered or delayed some components of assessment objectives. Transitions in the Title V Director in late 2004 and several key staff reduced the available resources to fully complete all the elements of the assessment. In addition, communities were saturated with state-required assessment and planning through other agencies and offices, so the timing for additional in-depth community-based needs analysis and priority setting seemed counter-productive during the 2004-05 assessment time period. The Title V assessment team was able to balance these challenges by taking advantage of the opportunity to use

the same consultants who had conducted the National Standards capacity assessments. With a new Title V Director and State Public Health Director, the MCH needs assessment findings will be utilized extensively to help plan and form new directions in Oregon.

2. PARTNERSHIP BUILDING AND COLLABORATION

Partnership building

The lead Title V Agencies, Office of Family Health (OFH) and Child Development and Rehabilitation Center (CDRC), engage in joint partnerships with other state agencies and organizations to coordinate MCH services and develop programs and policies. Some partnerships are mandated, but most are brought together to achieve common goals and objectives. OFH is organizationally part of the state Health Services, within the Department of Human Services. OFH and the Title V Director oversee and coordinate many state-level HRSA SPRANS and CISS grants focused on MCH health improvement. MCH and community health programs within the OFH include Prenatal Care, Child and Adolescent Health programs, including early childhood development screening, school-based health centers, teen pregnancy prevention, Immunization, and WIC. The DHS Health Services includes all health-related state agencies, such as Medicaid (OMAP-Office of Medical Assistance Programs), Mental Health and Addiction Services (OMHAS), and all public health services including HIV/AIDS prevention, Health Promotion and Chronic Disease Prevention, Tobacco Prevention, Injury and Suicide Prevention, Public Health Laboratory Newborn Screening, and the Primary Care Office and Health Systems Planning. Formal and informal intra-agency partnerships around are possible around many common issues of interest to the OFH and these programs and Offices. A rural health initiative, Enterprise for Healthy Rural Oregon, is a new initiative intended to bring public health and primary care in closer partnerships in rural areas to increase population access to care and preventive services.

The leading state-level partner with OFH programs is the Oregon Commission on Children and Families (CCF), reporting directly to the Governor and mandated to coordinate state and local agency planning around children and adolescents. The OCCF is a governor appointed commission separate from all other state agencies with the mission of coordinating all services and policies related to children and families. The membership of the commission includes executives from education, public health, welfare, protective services, child care, and Medicaid agencies, and representatives of parents and family organizations. Oregon's Title V and CSHCN programs are active participants in the OCCF state leadership roles and this collaboration, and various subgroups, including the Early Childhood Team. Oregon's Title V and CSHCN programs are active participants in the OCCF state leadership roles and this collaboration and the various activities and projects that arise from these efforts.

Locally, partnerships are maintained with the OFH through formal committees such as the Conference of Local Health Officials and the Association of Oregon Public Health Nurses. These are county health department groups that support and inform state public health and MCH programs on policies, funding decisions, and program development. Local

Commissions on Children and Families (LCCF), reporting to county commissioners, coordinate with county health departments. The LCCF are required to conduct assessments, identify priorities, and plan for activities in each county. In the last few years, every county has engaged local stakeholders in identifying local priorities, performance measures, and plans to implement best practices and strategies to address the needs and priorities.

OFH programs engage in other advisory groups, partnerships, and collaborations composed of state and local agency representatives, primary care, mental health, specialty, and oral health providers, child care providers, school districts, academic professionals, private health plans, managed care plans, parents, and family representatives. OFH maintains a matrix of all the partnerships of all its programs, showing who is in contact with various organizations. This list helps OFH staff reduce redundant contacts and increases the opportunity for integrating collaborative activities.

Needs Assessment Collaboration

Oregon's five-year needs assessment process involved a broad representation of state and local stakeholders to help identify needs. The Needs Assessment Leadership Group included representatives of the state public health offices and programs, CDRC Title V Programs, and a representative from the CLHO-MCH committee. The local county capacity assessments involved a wide variety of local partners from health and hospital providers to law enforcement and school districts. These community processes provided an opportunity to educate the participants about public health and about maternal and child health in particular. The feedback from those sessions was positive and momentum was gained for the local public health agencies to pursue follow-up activities and planning.

A state level capacity assessment was conducted within the Office of Family Health to complement the full state public health system assessment conducted earlier. This process was educational for staff to learn about programs throughout the organization and to understand how the ten essential public health services provide core guidance to program development and implementation.

Health priorities among the MCH population groups were conducted inviting primarily state public health agency staff and others as needed. These processes had the effect of educating state agency peers about the MCH population needs and health status, and to share how other public health programs are addressing issues of common concern to the Title V program. This process had mixed results in terms of partnership collaboration, but some program staff were inspired to create or renew internal partnerships to work on shared goals.

Results and Findings

The most revealing result of the collaborative efforts is the realization that Title V is relatively unknown among local communities and state programs as anything more than a funding source. Local providers understand MCH as a field of practice related to healthy births and children. State agencies are unaware of the role of Title V within the state public health system. In fact, improving Title V and MCH leadership was a high priority finding

throughout this assessment, including weaknesses in collaborations, constituency building, and partnership development. The assessment process, therefore, was effective in identifying the need for improved collaborations and probably limited in its effect in building or enhancing partnerships.

3. ASSESSMENT OF NEEDS OF THE MATERNAL AND CHILD HEALTH POPULATION GROUPS

Note: Assessment of Children with Special Health Needs is in the OCYSHN section

Review and consideration of both qualitative and quantitative information sources led to the selection of ten primary needs that were considered as a starting point for the Oregon Title V Needs Assessment (Figure 1)

Developing an Oregon MCH Profile

As described Section 2 *Partnership and Collaboration,* organizations such as the Conference of Local Health Officials-Maternal and Child Health Subcommittee and the Association of Oregon Public Health Nurses have provided valuable guidance and insight in determining the health priorities of Oregon's MCH population. Another key qualitative source utilized in this process was the set of 2004-2005 Local Public Health Improvement Plans.

In May of each year, Oregon county health departments submit Local Public Health Improvement Plans to the DHS, Health Services, Office of Community Health. The plans include each county's priorities, goals, objectives, activities and unmet needs (Appendix 3). As part of the Five-Year Needs Assessment, the Oregon Office of Family Health conducted an analysis of the *unmet needs* listed in the county plans submitted in May 2004. The goal of this analysis was to identify the most common needs facing women, children and families across Oregon. This information served as a basis for further needs assessment activities, goal setting, and planning by Office of Family Health programs.

Thirty-five health departments represent the 36 counties in Oregon. Thirty-two county plans were used for this analysis. Wherever possible the most recent version of each county plan was used. The 2004-2005 County plans were used for the overwhelming

Oregon Information Review

Qualitative Sources

- 2004-2005 Local Public Health Improvement Plans
- 2004-2006 Office of Family Health Plans
- Association of Oregon Public Health Nurses
- Conference of Local Health Officials-Maternal and Child Health Subcommittee
- Title V Leadership Group

Quantitative Oregon Sources (Partial list)

- Annie E. Casey Foundation
- Behavioral Risk Factor Surveillance System (BRFSS)
- Center for Disease Control and Prevention, YRBS
- Commission on Children and Families (CCF
- DHS, 2002 Smile Survey
- DHS, Child Abuse and Neglect Report, 2003
- DHS, Office of Disease Prevention and Epidemiology
- DHS, Office of Mental Health and Addiction Services
- Mother's Survey, Ross Products, Division of Abott Laboratories
- National Survey of Children's Health 2003
- OCPP- Hunger
- Office for Oregon Health Policy and Research
- Oregon Childcare Research Partnership
- Oregon Coordinated School Elementary Survey
- Oregon Department of Human Services (DHS) Center for Health Statistics and Vital Records
- Oregon Healthy Teens Survey
- Oregon Progress Board, 2003 Benchmark Performance Report
- PRAMS
- The Henry Kaiser Foundation
- United States Census Bureau

Figure 1

majority of counties. For a small number of counties, current plans were not available for these few counties 2003-2004 plans were examined. County plans could not be found for three counties.

There was a great deal of variation in the care used by the county personnel who wrote the executive summaries and unmet needs sections of the plans that were analyzed. This analysis is not intended to serve as a scientific, irrefutable proof of what all Oregonian counties need. It was created to assist in program planning and to identify policy directions for the Office of Family Health and partners.

Data detailing how the ten priority areas impact women, pregnant women, infants, children, and adolescents are included in bullet form where applicable. The tailored population specific information was gleaned from a comprehensive review of quantitative sources (Figure 1). A full copy of this data review can be found in Appendix 4.

Health Insurance Status

A lack of insurance or an inability for clients to afford deductibles and co-pays was the most frequently reported unmet need by Oregonian county health departments. Rising healthcare costs coupled with cuts to the Oregon Health Plan (Medicaid) have created a severe shortage of accessible healthcare for many Oregonians. Counties also reported that some providers refused to serve Oregon Health Plan clients. Lack of adequate insurance was cited by counties as a decisive barrier between Oregonians of all ages and primary care, mental health services, and dental services.

Women

- In 2003, an estimated 17% of Oregon women lacked health care insurance.[1] Among other states, the median proportion of women without insurance was 14% (2001).[2]
- Sixteen percent of Oregon women surveyed in 2003 reported that during the past year there was a time when they needed medical attention, but did not visit a doctor because of the cost.[3]
- The portion of women in Oregon without health insurance remained stable at 12% from 1999 through 2001 but rose to 17% in 2002 and 2003.[4]

Pregnant women

- The portion of births covered by private insurance has decreased from 60% in 2001 to 58% in 2003.[5] A steady increase occurred in the percentage of births paid for by government insurance; 32% in 1999 to 37% in 2003.[6] There was also an increase in the uninsured population during this time.
- Mothers whose deliveries were paid for by the Oregon Health Plan had higher rates of inadequate prenatal care according to the Kotelchuck Index[7] than mothers using insurance other than Medicaid; 24% and 19% respectively.[8]

Infants and Early Childhood

- In 2003, 12% of Oregon children age 0-3 were uninsured. This is twice the national rate of 6% for this age group.[9]

- An additional 10% of Oregon children 0-3 were not insured at some point during the 12 months prior to being surveyed (compared to 6% nationally).
- In 2003, government sponsored healthcare programs insured 26% of Oregon children age 0-3, 5% less than the national average.[10]
- More Oregon children were uninsured and fewer are covered by public insurance (Medicaid) than the national average in 2003.

Middle Childhood

- In 2003, an estimated 15% of Oregon children age 6-9 were uninsured at the time of being surveyed. This is almost twice the national rate (8.0%) for this age group.[11] An additional 7% of Oregon children age 6-9 were not insured at some point during the last 12 months, compared to 6% nationally. [12]
- Government sponsored healthcare programs insured an estimated 19% percent of Oregon children age 6-9, compared to 24% nationally, in 2003.[13]
- In Oregon, 23% of children age 6-9 lacked dental insurance that helped to pay for routine dental care in 2003, 2% more than nationally.[14]
- Lack of insurance among children under age 18 in Oregon is on the rise – having increased from a low of 7.6% in 1996 to 12.3% in 2004.[15]

Adolescents

- During a 2003 survey, 12% of Oregon adolescents age 10-17 were uninsured.[16] Nationally 8% were uninsured. [17] An additional 7% of Oregon adolescents age 10-17 were not insured at some point during the last 12 months, 2% more than nationally (5%).
- Government sponsored healthcare programs insured 14% percent of Oregon adolescents age 10-17, 6% less than the national average.[18]
- In 2003, 36% of Oregon adolescents age 18 to 24 reported not having any kind of health care coverage.[19] The percentage of 18 to 24 year olds without health insurance is almost 10% higher in Oregon than it is nationally.[20]
- In 2003, 1 in 4 (24%) adolescents 18 to 24 said that there was a time in the last 12 months that they needed to see a doctor, but could not because of cost.[21]
- Nine percent of all adolescents age 18 to 24 reported in 2003 not being able to access medical care when they needed it during the last twelve months. The majority of adolescents that were not able to access care (63%) cited that the main reason they were not able to get medical care was because of the cost, 22% said that they could not receive care because waiting period was too long.[22]

Disparity in health outcomes or health services available to racial, ethnic, or linguistic groups

Oregon counties reported concerns about their ability to adequately provide services for specific racial ethnic groups. Unmet needs cited by local health departments include: a need for services directed towards the Hispanic population, health services delivered in Spanish, the health needs of undocumented individuals, and health services for legal

immigrants. Several counties voiced concerns that Hispanics in their community are suffering worse health outcomes than the population as a whole.

Pregnant Women and Infants

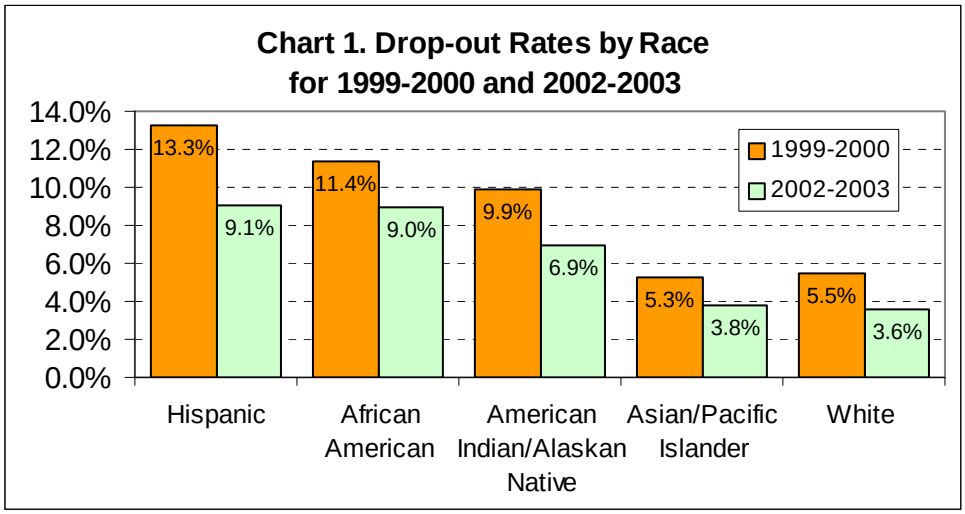
- The proportion of Oregon births with "inadequate" prenatal visits was substantially higher for minorities, specifically for American Indians (13%) and Hispanics (9%).[23] Eight percent of Non-Hispanic African Americans also received "inadequate care."[24]
- In Oregon, the infant mortality rate was twice as high for African Americans (9.9 per 1,000) as for whites (5.1 per 1,000).[25] Nationally, the rate of infant mortality for African Americans is even higher, 13.6 per 1,000 compared to 5.7 per 1,000 whites nationally.[26]

Childhood

- According to a 2001 report, children nationally who are in poverty, foreign born, live in a metropolitan area, or are Hispanic are less likely to have health insurance than children overall.[27]

Adolescents

- The dropout rates for Oregon high school students have been decreasing since 1994-95 from 7% to 4% for the 2002-2003 school year.[28] Although there have been decreases for each race and ethnicity, a large difference in rates by race and ethnicity still exists as you can see by the chart below (Chart 1).[29]



Source: Oregon Department of Education

Inadequate Prevention Programming- Variety of Topics

Counties stated a need for resources to offer prevention programming around a wide variety of topics including child immunizations and chronic disease prevention.

Qualitative sources listed in Figure 1 were unanimous in their concern about rising rates of childhood obesity.

Women

Chronic Disease and Risk Factors

- Heart disease was the leading cause of death for Oregon women from at least 1997 through 2001. In 2002 and 2003, heart disease slipped narrowly to the second leading cause of death (187.9 per 100,000).[30]
- In 2003, almost ¼ of all Oregon women are estimated to have high blood pressure.[31] Of those with high blood pressure, 77% report taking medication for their blood pressure.[32]
- Of the 73% of Oregon women who reported having had their cholesterol checked in 2003, 33% were diagnosed with high cholesterol.[33]
- There was an increase from 27% in 2000 to 31% in 2003 of Oregon women who reported that a healthcare professional has told them they have some form of arthritis.[34] Oregon has one of the highest rates of arthritis for women in the nation, ranked 42nd.[35]
- An estimated 16% of Oregon women (compared with 11% of Oregon men) reported having been told by a doctor or other health professional that they have asthma in 2002.[36] There has been little change in the percent of women that reported being diagnosed with asthma in their lifetime (1999, 14% to 2002, 16%).[37]
- In 2002, an estimated 6% of Oregon women have been diagnosed with diabetes[38], compared to 7% nationally.[39]
- In 2003, cancer was the leading cause of death for Oregon women (197.7 per 100,000).[40] In 2002, Bronchial and lung cancer accounted for 56.4 deaths per 100,000 women in Oregon[41] Breast cancer accounted for approximately one half as many deaths to Oregon women (28.3 per 100,000) as bronchial and lung cancer in 2002.[42]
- Breast cancer is much more common among women than lung cancer. However, because of the high mortality rate of lung cancer, nearly twice as many women die from lung cancer as from breast cancer.

Infant and Early Childhood

Preventive Medical Care and Screening

- Four percent of Oregon children age 0-3 did not have a preventive medical care visit or well-child visit in the past 12 months or since birth (compared to 3% nationally).[43]
- Ten percent of Oregon children age 4-5 did not have a preventive medical care visit or well-child visit in the past 12 months or since birth (compared to 8% nationally).[44]
- Oregon's youngest children receive fewer than the recommended number of preventive care visits, and fewer than their peer groups nationally.
- In Oregon, 93% of newborns are screened for hearing loss. Unfortunately, about 50% of those that are referred for a follow-up screen do not complete the second screening.[45]

- Completion of the 4th DTaP by age 2 is a good indication of children receiving all the necessary childhood immunizations and well-child visits. In 2003, an estimated 96% of all children, in Oregon and nationally, received the first 3 diphtheria, tetanus, and pertussis vaccines or DTaP's by age 2.[46] However, only 83% (+/-5.4) in Oregon (and 85% [+/-0.8] nationally) finished the vaccination series with the 4th DTaP by two years of age.[47]

Obesity

- Over the past three decades, the rate of obesity has more than doubled for preschool children aged 2 to 5 years and adolescents aged 12 to 19 years, and it has more than tripled for children aged 6 to 11 years.[48]

Middle Childhood

Preventive Medical Care and Screening

- In 2003, 21% of Oregon children age 6-9 did not have a preventive medical care visit or well-child visit in the past 12 months (compared to only 15% nationally).[49]
- The Oregon DHS Immunization Program has a long-term objective (from SY 2001-2002 through SY 2006 – 2007) to increase coverage/protection levels by 20% for D/T, polio, varicella, MMR, hepatitis B series for seventh graders. In SY 2001-2002 the baseline was 74% and for SY 2004-2005 the rate is 82%.

Obesity

- Over the past three decades, the rate of obesity has more than doubled for preschool children aged 2 to 5 years and adolescents aged 12 to 19 years, and it has more than tripled for children aged 6 to 11 years.[50]
- A 2003 survey estimated that 26% of Oregon children age 6-9 are considered overweight or having a body mass index of 95 or higher, this is 5.0% less than the proportion of overweight 6-9 year olds nationally.[51] An additional estimated 18% of Oregon children age 6-9 and 17% of children age 6-9 nationally are at risk for becoming overweight (having a body mass index of between 85 and 95).[52]

  [Note: Body Mass Index calculations have been criticized for not taking frame size or other concerns into account when calculated appropriate weight. The body mass index scale is based on adult heights and therefore may not be the best tool to measure children's appropriate weight, however, this is the most easy to use tool and only tool we have available.]

Adolescents

Preventive Medical Care and Screening

- In 2003, 18% of Oregon adolescents age 10-17 did not have a preventive medical care visit or well-child visit in the past 12 months.[53] This is 6% higher than the proportion of 10-17 year olds nationally that did not have a preventive medical care visit or well-child visit in the past 12 months (12%).[54]
- The CDC reported that the number of cases of pertussis or whooping cough, which is vaccine preventable, is at the highest level in 40 years. Almost 40% of those cases of pertussis are affecting the age 10-19 population, which until May 2005, was not vaccine preventable in this age group.

Obesity

- In 2004, 13% of Oregon 11th grades were at risk for becoming overweight (between the 85th and 95th percentile of weight for their height) and an additional 10% were obese.[55] Almost twice as many male 11th graders were obese than females.[56] Nationally in 2003, 2% more high school students[57] were obese (12%) and 2% more are at risk for becoming overweight (15%), than in Oregon.[58]
- For the older adolescents (age 18 to 24), 28% were overweight (BMI = 25-29) and 11% were obese (BMI = 30+) in 2003.[59] There was no change in the combined total proportion of overweight and obese 18 to 24 year olds from 2000 to 2003 (39%).[60]

Nutrition and Physical Activity

- In 2004, 71% of 11th graders and 81% of 8th graders in Oregon participated in rigorous exercise for 20 minutes 3 or more days a week.[61] For 11th graders, this is up from 60% in the 1997 survey.[62]
- Twenty-one percent of 11th graders and 30% of 8th graders reported eating 5 or more servings of fruit and vegetables in 2004.[63]

Women's Reproductive Health

The two most common issues raised by Oregon counties regarding this topic are: 1) There is a lack of obstetric providers in the county, 2) There are insufficient prenatal care resources for pregnant women in the county. Other issues mentioned include pregnant women abusing alcohol, tobacco, and other drugs and a need for increased CAWEM and WIC resources.

The issue of unintended pregnancy was raised by Office of Family Health staff as a pressing public health concern. This concern is reinforced by findings from the Institutes of Medicine (IOM) that unintended pregnancies are an important indicator for the MCH status.[64]

Prenatal Care

- In 2003, 22% of women who gave birth in Oregon did not have 80% or more of the recommended number of prenatal visits.[65] The percentage of Oregon mothers that received prenatal care beginning in the first trimester has increased steadily since 1990 when it was at 76%.[66]
- In 2003, about 6% of Oregon women receive "inadequate" prenatal care; defined as having 5 or less prenatal visits or care that began in the 3rd trimester.[67]
- In 2002, 89% of Oregon's low-income pregnant women that were on Medicaid received prenatal care in the first 4 months of pregnancy, exceeding the DHS Performance target for 2005 of 87.5%.[68] Among this population, prenatal care utilization in the first 4 months of has increased substantially since 1999 (1999, 84% to 2002, 90%).[69]

Unintended Pregnancy

- An IOM report states: "A woman with an unintended pregnancy is less likely to seek early prenatal care and more likely to expose the fetus to ... tobacco or alcohol.

The child of an unwanted conception especially (as distinct from a mistimed one) is at greater risk of being born at low birthweight, of dying in its first year of life, of being abused, and of not receiving sufficient resources for healthy development. The mother may be at greater risk of depression and of physical abuse herself, and her relationship with her partner is at greater risk of dissolution.[70]

- An estimated 53% of all Oregon pregnancies were unintended (new mothers reporting they would rather have been pregnant later or not at all) or terminated in 2002; this does not meet the 2005 DHS Performance target of 48.5%**.**[71]
- The portion of Oregon pregnancies that were unintended or terminated improved very little over the past four years (54%).72
- A major issue related to unintended pregnancy is the availability of emergency contraception (E.C.). In Oregon 25% of new mothers reported not having heard of E.C. in 2001.[73]

Low Birth Weight

- In 2003, 6.1 per 1,000 live births in Oregon were low birth weight (<2500 grams).74 Nationally, 7.8 per 1,000 live births were low birth weight in 2002.75
- The rate of live births (including multiple births) in Oregon that were low birth weight was about 5.4 per 1,000 live births from 1996 through 1999, but have since increased steadily to 6.1 per 1,000 live births.[76]

Dental Insurance as a Barrier to Receiving Oral Health Care

Dental insurance was named independently of other types of health insurance as a need by Oregon counties. Lack of dental coverage under the Oregon Health Plan was cited as a specific barrier to oral health faced by low-income residents. More information about oral health access concerns can be found under the priority issue entitled *Lack of Dental Services and Providers*. As part of the 2004-2006 Office of Family Health Plans, counties cited oral health care for children as a prime concern.

Adults-General

- For every adult (19+) without health insurance in the U.S., the CDC estimates that there are 3 without dental insurance.[77]

Infant and Early Childhood

- Twenty-six percent of children age 0-3 in Oregon and nationally in 2003 did not have insurance that helped pay for any routine dental care. [78]
- A 2003 survey found that 29% of Oregon children age 4-5 did not have insurance that helped pay for any routine dental care (compared to 22% nationally). [79]

Middle Childhood

- Rates of individuals who lack dental insurance are generally more than twice as high as rates of individuals who lack medical insurance rates. In Oregon in 2003, an estimated 23% of children age 6-9 lacked dental insurance that helped to pay for routine dental care, two percent more than nationally.[80]

Adolescents

- In 2003, almost 1 in 4 (24%) of adolescents 10-17 lacked dental insurance that helped to pay for routine dental care, 2% more than nationally.[81]

Lack of Dental Services and Providers

More than half of Oregon's practicing full time equivalent (equivalent of working 40 hours per week) dentists practice in the Portland metropolitan area. Twenty-two of Oregon's 36 counties (61%) are experiencing dental professional shortages among sections of their populations including low-income residents and the homeless.[82]

Women

- In 2002, an estimated 17% of Oregon women self-reported they had not been to a dentist for teeth cleaning in more than 2 years.[83] An estimated 70% of Oregon women had visited a dentist in the past year (2% less than nationally) according to a 2004 source. [84]

Pregnant Women

- Pregnancy is a time when women's teeth and gums are particularly sensitive to decay. In 2001, an estimated 56% of new Oregon mothers had not had their teeth cleaned in the past year.[85]

Infants and Early Childhood

- In 2003, an estimated 15% of Oregon children age 0-3 did not visit a dentist in the past 12 months for any routine preventive dental care (compared to 13% nationally).86
- Nationally and in Oregon in 2003, 7% of children age 4-5 did not visit a dentist in the past 12 months for any routine preventive dental care. [87]

Childhood

- In 2003, 6% of Oregon children age 6-9 did not visit a dentist in the past 12 months for any routine preventive dental care, (compared to 5% nationally).
- In 2002, 42% of Oregon 8-year-olds had dental sealant on their permanent molars, compared to 23% nationally. The Healthy People 2010 goal for dental sealants for this population is 50%. [88]

Adolescents

- According to a 2003 survey, 7% of Oregon adolescents age 10-17 did not visit a dentist in the past 12 months for any routine preventive dental care; this is slightly higher than the portion nationally (6%).[89]
- In 2004, 25% percent of Oregon 11th graders and 28% of Oregon 8th graders did not visit (did not receive a check-up, exam, teeth-cleaning or other dental work) a dentist or dental hygienist in the last 12 months.[90]
- Thirty-two percent of older adolescents, age 18-24, reported not visiting a dentist in the last 12 months in a 2002 survey.[91]

- Fluoridated water helps to protect children's teeth, however in 2002 only 23% of the Oregonian population was getting fluoridated water. This is the 5th lowest proportion in the nation.[92]

Insufficient Services and Resources for the Geriatric Population

While the geriatric population is not typically considered to be part of the MCH population, the Oregon analysis of the 2004-2005 Local Public Health Improvement Plans revealed that counties are overwhelmed by the needs of this population. A large number of needs were listed for this population including but not limited to: dentures, eyeglasses, hearing aides, long term care, and assistance with activities of daily life. This priority area will not be explored in this Title V document but is being considered as a population focus by the Office of Family Health.

Tobacco Use

Tobacco use is a significant precursor for chronic disease. Decreased tobacco prevention funding is blamed by counties for increased in tobacco use. Counties stated that they had needs for both cessation and prevention resources.

Women

- In 2002, about 35% of women in Oregon that had smoked 100 cigarettes in there lifetime smoked on a daily basis.[93]
- There has been little change in the portion of Oregon women that smoke on a daily basis since 1999. [94]

Pregnant Women and Infants

- In 2003, 12% of all Oregonians who gave birth reported using tobacco while pregnant.[95]
- Between 1999 and 2003 the percent of Oregon women using tobacco while pregnant dropped from 15% to 12%. [96]
- In 2001, 16% of Oregon mothers with 6 month olds were smoking at least 1 cigarette a day and 27% of them said that there was another person in the house that smoked cigarettes, pipes, or cigars.[97]
- Women under 25 are twice as likely to smoke during pregnancy as those 25 or older, 20% in the younger group compared to 6-10% in the older group. [98]

Childhood

- Tobacco use by elementary aged children is not well documented in Oregon.

Adolescents

- Of Oregon 11th graders in a 2004 survey, 17% reporting smoking cigarettes at least one day during the past 30 days.[99] Nationally in 2003, 22% of high school students reporting smoking cigarettes during the last month.[100]

Accessible Mental Health Services

Counties listed mental health services for the general population as a need for their residents. Rising healthcare costs coupled with cuts to the Oregon Health Plan (Medicaid) have created a severe shortage of mental health resources for many Oregonians. Lack of adequate insurance was cited by the counties as a decisive barrier between Oregonians of all ages and mental health services.

Specific mental health issues of concern include Postpartum Depression, and adolescent depression and psychosis. There is a lack of data on the available mental health infrastructure available to Oregonians.

Women

- An estimated 12% of Oregon women (3% higher than men) reported that their mental health was "not good" for 15 or more days of the previous month in 2003. [101]
- About 9% of Oregon women over 18 (126,000) are estimated to need mental health treatment.[102] Only an estimated 38% of these women are receiving treatment. [103]
- Since 1999, the portion of Oregon women that reported their mental health was not good for over half of the previous month fluctuated between 10% and 12%. [104]

Suicide

- In 2002, three percent of Oregon women self-reported that they "seriously considered" suicide during the past year. [105]
- Suicide was the 17th leading cause of death for women in Oregon during 2002 causing 85 deaths (4.8 per 100,000 women).[106]
- The rate of hospital discharge for suicide attempts was almost twice as high for women as for men in 2003.[107] Oregon women make more attempts at suicide than Oregon men, but in 2001 there were more deaths to suicide for men (23.13 per 100,000) than for women (6.28 per 100,000).[108].
- Middle-aged women are at increased risk for suicide, compared to both younger and older women. The rate of suicide deaths for females age 35-44 is 7.4 (per 100,000), and age 45-54 is 11.5 compared to 3.4 for females 24-35 and 6.3 for females 55-64 and lower rates for all other Oregon women.[109]

Pregnant Women

Perinatal and Postpartum Depression

- One of the Healthy People 2010 objectives is to reduce postpartum depression. Recent analysis of various sources (including both self-reported and clinically diagnosed) of postpartum depression data estimated the prevalence of postpartum depression around 13% of women nationally and that about 12% of women suffer from depression during the 2nd and 3rd trimesters of pregnancy.[110]
- It is estimated that health care providers identify only 20-30% of perinatal mood disorders, which includes depression during pregnancy and up to 1 year postpartum.[111]
- Women who are suffering with perinatal depression are more likely to face substance abuse issues, marriage problems, employment problems and suicidal

concerns and they are less likely to promote the child's cognitive and emotional development. [112]

Infant and Early Childhood

- Six percent of Oregon parents identified their 0-3 year old as having difficulties with emotions, concentration, behavior, or difficulty getting along with others (compared with 8% nationally).[113]
- Eight percent of Oregon parents of 4-5 year olds identified these difficulties in their children (compared to 12% nationally).[114]

Middle Childhood

- One in every 5 children and adolescents nationally are affected by mental health problems at any given time. At least 1 in 10 children, have a serious emotional disturbance.[115]
- In 2003, among parents of Oregon 6-9 year olds, an estimated 18% - both in Oregon and nationally - identified their child as having difficulties with emotions, concentration, behavior, or being able to get along with other people.[116]

Adolescents

- Nine percent of 10-17 year olds in Oregon and nationally had an emotional, developmental, or behavioral problem for which their parent believes they need treatment or counseling during 2003. [117]
- In 2003, 21% of Oregon parents and 19% of parents nationally identified their 10-17 year old as having difficulties with emotions, concentration, behavior, or being able to get along with other people.[118]
- During 2004, 46% of all 11th graders reported feeling depressed at least 1 day a week.[119]
- There has been little change in the proportion of 11th graders that felt depressed at least 1 day a week from 2000 to 2004.[120]
- Bi-Polar disorder may be more severe in and as common in children and adolescents than adults. One percent of 14-18 year olds nationally met the criteria for bi-polar disease or cyclothymia, a similar but milder illness, in their lifetime in an early 1990's NIMH supported study.[121]

Suicide

- The rate of death by suicide for 15-24 year olds was 12.6 per 100,000 in 2003.[122] .
- About 13% of 11th graders annually reported seriously considering suicide over the 4 years that the Oregon Healthy Teens Survey tracked this information (since 2001).[123] Nationally, the percentage of high school students reporting seriously considering suicide decreased from 24% in 1993 to 17% in 2003, but no change was seen in the percentage of self-reported suicide attempts (9%).[124]

Alcohol and Other Drug Use

Alcohol and other drug counseling and treatment services for the general population were listed as needs by counties. The need for substance abuse treatment services was linked by counties to an overall lack of mental health services.

Women

Alcohol

- According to a 2004 national and state-by-state report card, Making the Grade on Women's Health, Oregon has the 34th worst record for binge drinking with 9% of Oregon women binge drinking during a given month.[125]
- In Oregon in 2002, an estimated 6% of women who reported having at least one drink in the past month drank at least one alcoholic beverage per day on average.[126]
- In 2002, Chronic Alcoholic Liver Disease accounted for 89 deaths of Oregon women and another 41 deaths were alcohol induced by other means.[127]
- There has been no change in the portion of adults (15%-16%) in Oregon and nationwide that report binge drinking since 1990. [128]

Illicit Drugs

- A 2003 report identifies that approximately 10% of Oregon adults (including men) "abused or depended" on illicit drugs. [129] An additional 29% of Oregon adults reported "some use" of drugs, but do not report abuse or dependency. [130]
- The most commonly used illegal drug is marijuana. [131]
- In 2002, 25 deaths of Oregon women were attributed to drug use (besides alcohol), most of which were to women between the ages of 35 and 54. [132]

Drug and Alcohol Treatment

- In 2003 it was estimated that 140,000 Oregon women over the age of 18 needed treatment for addiction to alcohol or drugs and only 18,000 or 13% of all adult Oregon women that needed treatment for alcohol or drug addiction are currently enrolled in treatment programs.[133]

Pregnant Women

Alcohol

- In 2001, 52% of women in Oregon that gave birth reported consuming alcohol in the 3 months before pregnancy.[134]
- According to a 2002 Mental Health report, an estimated 18% of the total female population in Oregon is in need of, but not able to receive treatment for, addiction and substance abuse issues.[135]
- The portion of women self-reporting that they abstained from alcohol during pregnancy has steadily increased from 95% in 1990 to 98% in 2003.[136]
- Sixteen infants in Oregon in 2003 were born with fetal alcohol syndrome.[137]
- In 2002 infants with mothers that used alcohol during pregnancy had twice the rate of perinatal period[138] deaths (11.9 per 1,000 live births) than infants of mothers that did not use alcohol during pregnancy (5.3 per 1,000). [139]

Illicit Drugs

- Drug use is commonly underreported. In 2003, almost 99% of Oregon mothers self-reported not using illicit drugs during pregnancy.[140]

- There has been little change in the portion of pregnant women who self-report using illicit drugs while pregnant since 1999. [141]

Childhood

- According to a 2003 report, alcohol and/or drug abuse was suspected to be a factor in 43% of child abuse or neglect cases.[142]
- Drug and alcohol use by elementary aged children is not well documented in Oregon.

Adolescents

- The percentage of 8th graders that drank alcohol in the past 30 days increased from 16% in 1997 to 29% in 2004. Most recently a 4.0% increase in the 8th grade proportion of students drinking appeared between 2003 (25.0%) and 2004 (29.0%). [143]
- In 2004, 45% of Oregon 11th graders reporting drinking alcohol at least once, for non-religious reasons, during the past 30 days. [144] This is the same percentage as the national average for 9th- 12th graders.[145]
- In 2002, 63% of Oregon 18 to 24 year olds drank alcohol in the last 30 days. [146]
- In Oregon, there has been little fluctuation in the percentage of 11th graders that have drunk alcohol at least once during the last 30 days. [147] Nationally, the adolescent alcohol use trend has decreased to match the Oregon trend. [148]

Binge Drinking

- In 2004, 29% of Oregon 11th graders who reported that they drank in the past 30 days reported binge drinking[149] at least once in the past month, about the same as high school students nationally in 2003 (28%).[150]
- In 2002, 50% of Oregon 18 to 24 year olds reported binge drinking [151] compared to 28% of 18-24 year olds nationally in 2004. [152]
- Since 2001, there has been an increase of about 4% in the portion of Oregon 11th graders that report binge drinking.[153] Nationally, there has been a decreased trend in binge drinking.[154]

Drug Use and Treatment

- During the 2001-2002 fiscal year, it was estimated that about 7,150 adolescents age 10-17 were in alcohol and drug treatment facilities. The need for alcohol and drug treatment facilities was estimated to be for about 42,650 young adolescents, far outweighing the current available treatment centers.[155]

SUMMARY OF POPULATION HEALTH STATUS NEEDS

The assessment information from counties is clearly supported by the population health status data. County health departments and nurses are aware that the populations in their communities are losing both public and private insurance coverage for health care and dental care, and insurance coverage rates reflect this gap. The low birthweight rates of Oregon newborns are rising, though fewer pregnant women are smoking. While tobacco use is slowly decreasing, higher risk behaviors, such as binge drinking and illicit drug use, are still a problem for most communities. Hispanic and African Americans experience disparities in health care access for women and children. Obesity prevention for children and adolescents such as physical activity and nutrition is a critical need for overall preventive health across the lifespan. Children and adolescents are not receiving the optimal number of well child visits and therefore do not have the appropriate early screening and referral for developmental and chronic diseases prevention and management. The overall health status of populations could be improved with universal access to medical, dental, and preventive care services. Providers for these services need to be competent and skilled in screening, referral and treatment, especially in rural areas and among those populations who experience greater disparities in Oregon. Health status data sources for women, pregnant women, infants and adolescents exist and are improving. However, data sources for school-age children (middle childhood) and for mental health status for all populations is needed to more accurately measure outcomes in relation to the anecdotal and observational information provided by Oregon's local providers.

4. PROGRAM CAPACITY BY PYRAMID LEVELS

The Oregon Title V capacity assessments used nationally developed instruments and office-level activities to create an overall view of strengths and weaknesses. The instruments are based on the Ten Essential Public Health (or MCH) Services and office process assessed the early childhood system integration in OFH. Additionally, county health departments conducted an assessment of local adolescent health capacity. The results are sorted according to the assessment instrument:

- *Public health system* – assessed by the National Public Health Performance Standards (NPHPS)
- *MCH system* – assessed by the Capacity Assessment for State Title-V (CAST-5)
- *Office-level early childhood systems* – Appreciative Inquiry of staff in Office of Family Health (OFH); includes Title V-MCH, Family Planning, Oral Health, WIC, and Immunization programs
- *County health adolescent health capacity* – Capacity Assessment of State Adolescent Health adapted for brief local capacity assessment.

Background

The DHS Health Services, Office of Family Health (Title V Agency) and the Conference of Local Health Officials (CLHO) provided leadership in moving Oregon public health systems in line with public health core functions and essential services. In early 2004, DHS and CLHO conducted the Local National Public Health Performance Standards Assessment developed through CDC's Public Health Practice Program Office for nine county health departments. (http://www.phppo.cdc.gov/ NPHPS/index.asp) Following these local assessments, the State Public Health version of the NPHPS was conducted in the summer of 2004.

As the Office of Family Health programs began planning the five-year needs assessment, it became clear that these assessments would provide essential information for the Title V assessment. The OFH decided to augment these assessments with MCH-specific capacity assessment using the CAST-5 (Capacity Assessment for State Title V Programs) developed by AMCHP and the Women's and Children's Health Policy Center (http://www.amchp.org/policy/data-cast5.htm). The Assessment team adapted and integrated the tools for local use, assessing only those Essential Services where the National Public Health Standards did not adequately cover an MCH service.

LOCAL CAPACITY ASSESSMENT PROCESS

In 2004, Oregon conducted National Standards assessment of 9 counties. To add to the information from that assessment, the Title V program selected three counties (Lincoln, Klamath, and Clackamas Counties) to assess public health and MCH capacity. Two counties participated in both the National Performance Standards and MCH assessments (Lincoln and Klamath), and one county who had already conducted the NPHSP, participated in an MCH-only assessment. These were conducted in December 2004-February 2005. All 10 Essential Services were assessed using the NPHPS tool. The CAST-5 tool was adapted for local level service delivery and 5 of the 10 Essential MCH Services that were not adequately addressed by the NPHPS tool. These 5 Essential Services were selected because it was reasoned the NPHPS covered the essence of MCH public health, and that the following Essential Services MCH Standards would provide the capacity information needed:

#3: Inform, educate, and empower the public
#4: Mobilize partnerships
#5: Leadership for policy development and advocacy
#7: Link and assure access to services
#9: Evaluate effectiveness and quality of services

Lincoln County (2003):

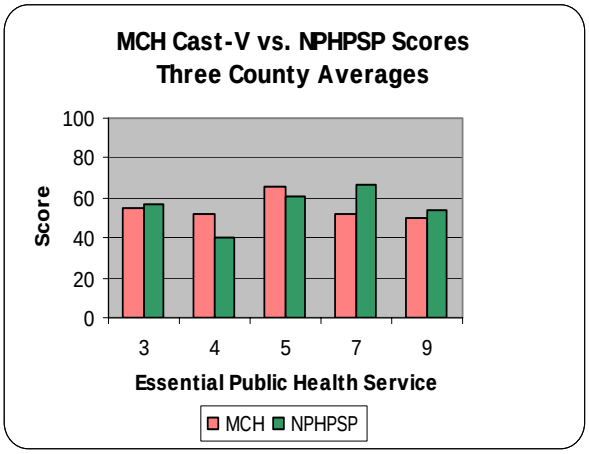
Population	44,400
Children <24	12,604
Pop. Density	45/sq mi
Births	429
Medicaid Births	249
Birth rate	9.5/1000

Clackamas County (2003):

Population	356,250
Children <24	119,341
Pop. Density	181/sq mi
Births	4,019
Medicaid Births	1,134
Birth rate	11.4/1000

Klamath County (2003):

Population	64,800
Children <24	22,121
Pop. Density	11/sq mi
Births	836
Medicaid Births	435
Birth rate	12.9/1000



Percentage scores show the Standard is:
Fully Met - 76-100% of the time
Substantially Met - 51-75% of the time
Partially Met - 26-50% of the time
Unmet - 0-25%

County health departments invited staff, local stakeholders, partners, and parent representatives from the communities, with participation ranging from 25 people to 60 people. Both instrument scores used the scale of the NPHPS tool for consistency.

The NPHPS results were consistent with the nine county assessments previously conducted using the NPHPS tool. The scores across all three counties had a fairly consistent correlation between the CAST-5 results and the NPHPS results.

The local process included SWOT (Strengths, Weaknesses, Opportunities and Threats) with key health department managers and stakeholders to facilitate action on the assessment findings. All three health departments identified *strengths* that included:

- Community collaboration
- Strong and dedicated staff
- Community support
- Community programs
- Shared planning and resources

The lead *weaknesses* and concerns across the three health departments included:

- Poor access to care
- High rates of socio-economic problems in the community, including drug use, child abuse, poverty, unemployment
- Lack of resources
- Poor connections with school health

Essential Maternal and Child Health Services

1. Assess and monitor maternal and child health status to identify and address problems.
2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.
3. Inform and educate the public and families about maternal and child health issues.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.
6. Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.
7. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

LOCAL ADOLESCENT HEALTH CAPACITY ASSESSMENT

In order to understand the capacity for county health departments to serve the adolescent population, the Oregon Adolescent Health Section (AHS) adapted a state level capacity assessment tool for use in measuring county adolescent health capacity. The state level tool was developed by the Association of Maternal and Child Health Programs and the National Network of State Adolescent Health Coordinators (NNSAHC) with support from the Annie Casey Foundation in 2004.

The modified tool developed by AHS was distributed to all 35 health departments in the state. Participants were asked to complete the tool, reporting a consensus score using a group process that involved a minimum set of key informants and decision makers. The tool consisted of 15 questions to measure 6 key capacity areas. There was a 77% response rate (27 of 35 local health departments). Participating county health departments received their highest scores in the *Technical Assistance* and *Effective Partnership* capacity areas. Almost half (48%) of reporting counties rated themselves as good or excellent on the *Technical Assistance* capacity area. (Appendix 5 – full results)

One third (33%) of counties rated themselves as good or excellent in the capacity area for *Effective Partnerships*. Interestingly, the lowest mean score and highest mean scores on any single question within the tool were received by questions within the same capacity area-- *Elements of Effective Partnership* (Figure 2). Question four which asks about relationships with youth and families as well as youth development activities received the lowest score. This is an important finding as youth development (i.e. Positive Youth Development) is a rapidly developing framework for working with youth that has received considerable national attention and recognition during the last decade. Within the youth development framework, adolescents are empowered to both contribute to their community and participate in community decision making[156]. In contrast, public health has traditionally utilized a more risk-protective factor orientation paradigm. It appears, while local public health departments demonstrate overall effective community partnering skills they are less centered on engaging youth and their families directly.

Elements of Effective Partnerships for Adolescent Health
3) Does your local health department have *Informal and Formal Partnership Structures?* Some examples include evaluation, accountability, reciprocal relationships, coordination of resources, and/or collaboration.
4) Does your local health department have *Family and Youth Partnerships and Youth Development* activities? Some examples include youth and family participation/input, appropriate representation, youth and family empowerment, and/or youth/family/adult communication.
5) Does your local health department have *Youth Serving Partnerships?* Some examples include appropriate representation, health and human service partnerships, partnerships with state and community organizations, and initiatives, partnerships with education, and/or partnerships to reach out-of-school youth.

Figure 2

The weakest capacity area for counties was *Planning and Evaluation*. Less than one fifth (18.5%) of Oregon counties rated themselves as good or excellent on this capacity area. This finding confirms that Oregon counties have limited *formal commitment* to adolescent health, and was evidenced by two questions. One question asked counties if they had an adolescent health *focal point*. Some examples include a dedicated adolescent health program, or a written statement such as a mission statement or strategic plan which included adolescent health priorities. The second question in the formal commitment capacity area asked if the local health department had dedicated adolescent health staff. Less than half (44%) of the reporting counties rated themselves as good or excellent on this element. In Oregon counties, the needs of the adolescent population are often addressed by staff who serve multiple programs or in some cases the entire Maternal and Child Health population. These finding underscore the limited resources with which many Oregon counties must serve their populations and may reflect that historically Maternal and Child Health programs have been built on programs designed for infants and their mothers.

Several positive and unexpected outcomes occurred as a result of this process. Numerous counties remarked that the brief group process used to fill out the tool was one of the first times they had gathered to review and consider their adolescent population as a whole within their public health system. Typically they reported a pattern of discussing adolescents just within a specific program (e.g. family planning). The process that was used served to promote dialogue and enhance connections. One participating county, as direct result of engaging the tool, began an adolescent health strategic planning process. Another county increased their formal commitment to this population by re-allocating staff time to create a dedicated position for their adolescent health programming.

STATE CAPACITY ASSESSMENT

A statewide public health system assessment, using the National Public Health Standards, was conducted in June of 2004. About 60 stakeholders and partners participated in the two-day process, resulting in critical information about Oregon's public health system relevant to the Title V health system. The participants included state and local public health leaders, private and non-profit health organizations, legislators, environmental health leaders, and others interested in state public health system improvement.

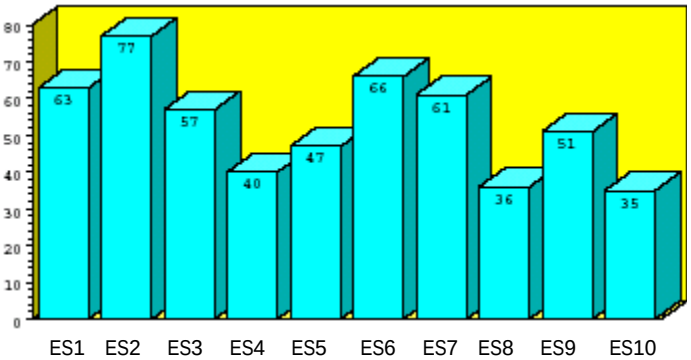


FIGURE 3

The State NPHPS assessment results showed 4 Essential Services were " partially met" (Figure 3):

#4: Mobilize Partnerships to identify and solve health problems

#5: Develop policies and plans that support individual and statewide health efforts

#8: Assure a competent public and personal health care workforce

#10: Research for new insights and innovative solutions to health problems

The participant discussions in this process identified specific system deficiencies. These included:

(1) The absence of a statewide profile that is accessible to local health departments and state-level partners which documents causes of death, injury, and illness; and identifies changes and trends in factors related to health status of Oregonians;
(2) The absence of a state-wide public health improvement plan to mobilize communities to improve health status;
(3) A lack of consistent efforts to work with national and state-level organizations and the academic community to address public health workforce challenges; and
(4) The absence of a state-wide public health research agenda.

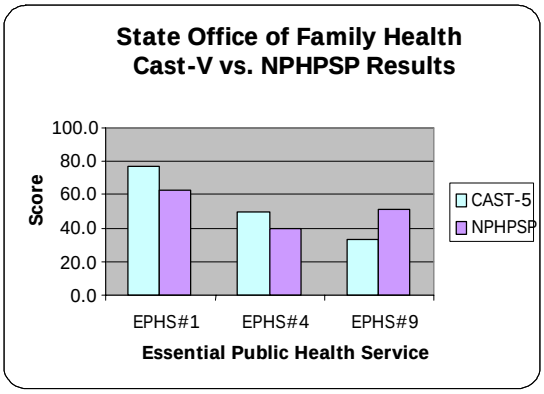
Themes supporting these deficiencies included the observations that both the state-level and the state-wide public health systems are seriously under-resourced, and that the current organizational structure of the state public health agency is seriously flawed, resulting directly in significant limitations in public health performance.

MCH System Findings

Following this in-depth system assessment, the Title V program decided to assess the Title V Agency – Office of Family Health – with staff, using the CAST-5 assessment instrument. The OFH assessment focused on 3 Essential Services that more adequately covered MCH programs not represented in the NPHPS, and associated with the core public health functions – assessment, policy development and assurance. The essential services selected were:

#1: Assess and monitor health status
#4: Mobilize partnerships
#9: Evaluate effectiveness and quality of services

Participants in the OFH-CAST-5 assessment included managers and staff from programs in OFH including WIC, Immunization, Oral Health, Family Planning, Women's Health, Genetics, and Maternal and Child Health programs.



The results for the State Office of Family health show a relative strength in Essential Services #1 and #4 compared to the State Public Health Standards. However, Essential Service # 4 – mobilizing partnerships – scored less than 50% or "partially met." This result is consistent with the results of the Early Childhood Systems assessment concerning the need to convene constituencies and partnerships. The greatest deficiency from this assessment was #9 – evaluation of effectiveness and quality – which scored much lower than the statewide NPHPS. The OFH staff assessed program evaluation almost in the "unmet" scoring at around 30%. Program evaluation at both the

state and local levels, especially for use in policy development and partnership building came as the most consistent need across the county assessments, the adolescent health assessment and the state level MCH assessments. The lack of knowledge about the effectiveness of current programs greatly reduces the ability of public health and MCH advocates to adequately make the case for much needed interventions, programs and policies.

STATE-LEVEL EARLY CHILDHOOD HEALTH SYSTEMS ASSESSMENT

Oregon's early childhood systems planning activities included an "appreciative inquiry" assessment of programs within the Office of Family Health (OFH). The purpose of this assessment was to develop a shared understanding of OFH's role and work in the Early Childhood System; and to develop strategies for strengthening OFH's contribution to Oregon's system of early Childhood Services and supports. An outline of the process is included in Appendix 6, ("Early Childhood Assessment Outline"). The process was focused on planning in *five areas* for the 0-8 year old populations:

- Health insurance and Medical care
- Mental Health and Social-Emotional Development
- Early Care and Education
- Parent Education
- Family Support

The process took advantage of program section staff meetings, then staff self-selected participation in topic-specific sessions in each of the five focus areas. The process culminated in an All-Staff meeting to bring together the threads of information in response to the following questions:

- How can the Office of Family Health best promote the health of Oregon's Young Children and families through the Early Childhood System?
- Dreaming to design session: How do we use what we know about our strengths/ contributions, and our dreams for OFH's work with the Early Childhood System to craft a plan for action?

The answers of these questions convey the needs at the OFH level (Appendix 6a - ECHS All Staff Meeting Results). As the ECHS is closely intertwined with Title V and MCH programs, the results of this process are included to round out the picture of capacity strengths and needs from statewide public health system to local public health and MCH systems, and then to the State MCH office Level.

SUMMARY - PYRAMID LEVEL OF SERVICES ASSESSMENT

A detailed summary of the all the capacity assessment is in Appendix 7 and below is a summary by Title V Pyramid Level of Services.

Direct and enabling:

Capacity assessment of the Ten Essential Services identified Oregon's state public health program as fairly strong in linking people to services, where services are available. Local

health departments consider services to be less than adequate in regards to assuring availability and accessibility of services. Populations experience disparities or direct service barriers related to reduced Oregon Health Plan/Medicaid benefits, low reimbursement rates reduce provider incentive to serve clients not covered by private insurance, and rural and frontier areas lack specialty services or electronic access to specialty services, especially pediatric specialist, mental health professionals, and dentists. For Oregon's undocumented and migrant populations, state and local capacity assessments identified the need for existing health systems to improve integration of cultural and linguistic competency into service delivery and for the provider workforce to be better prepared to provide services to high risk populations of other cultures. Quality improvement efforts should be increased at the state and local levels through evaluation of client perspectives on service needs.

Strengths among the delivery services include Oregon's WIC nutrition screening services where screening and referral for prenatal care, family planning, immunization, primary care, Oregon Health Plan enrollment, developmental screening, Head Start, and other social services are active. Nurse home visiting and high infant programs, such as Babies, First! and CaCoon are effective in providing screening and referral to appropriate services, even with stretched resources. Communities are locally mobilized in many areas and have the will to innovate, with few resources, to improve through integration or coordination of existing health services. During assessment meetings, community participants had many ideas to create public, interactive websites to link people to adequate services and information.

Population-Based Services:

The state's capacity for administering and implementing MCH population-based services are predominantly federally funded programs, such as early newborn hearing screening, immunization, oral health, injury prevention, fetal alcohol syndrome, and early childhood systems planning. State and local support of MCH population-based programs are limited or non-existent. These federal population-based services were perceived as adequate in the capacity assessment discussions. Population-based interventions or services needed for the MCH population included universal developmental screening among public and private providers, integration of primary care and mental health services, accessible prevention, screening, diagnosis and treatment for mental health/social emotional development, and coordinated school health models to expand community-based health system partnerships.

The most significant weakness identified by participants in all the capacity assessment was the lack of state support for public health and MCH programs. To increase this support, improved infrastructure services are needed to better inform and advocate to policy makers for this support.

Strengths in Oregon's MCH population-based services include adequate evaluation of behavioral and risk survey data for epidemiological analysis of population health. Individual programs use data such as PRAMS (Pregnancy Risk Assessment Monitoring Survey), BRFSS (Behavioral Risk Factor Surveillance Survey), and Oregon Healthy Teens (Oregon's youth risk behavior survey). This information is used to identify areas of

population health or risks in need of intervention and to develop programs or grant initiatives. However, again, the resources for these programs are limited to categorical federal funding opportunities, or limited development and coordination through Title V resources. With the strength of communities and state and local public health staff and leadership, assessment participants acknowledged that opportunities exist to shift and increase resources that would improve systems and services to meet their community health needs.

Infrastructure Building Services:

The capacity assessments in Oregon were initiated because public health organizations and professionals perceived that public health was losing its effectiveness and ability to serve and address the population's needs. With state-level reorganization, reduced or shifted funding policies, and a need to increase coordinated services for high risk populations, the capacity assessments provided the means to determine weaknesses and strengths of the public health delivery system. The findings around the 10 Essential Services were fairly consistent across the various assessment activities, providing direction about the needs of public health and MCH infrastructure systems. The Essential Services that showed the greatest need overall were:

4 Mobilize partnerships
7 Link & assure access to services
8 Workforce development
9 Evaluate effectiveness and quality of services

The assessments rated strongly in the availability of public health and MCH surveillance and other data information. However, there is a need to effectively analyze and use this data for community profiling, for monitoring trends for continuous health status improvement, and for disseminating to the public and policy makers to advocate for public health interventions. The ability to convene and mobilize community coalitions and partnerships includes increasing the community knowledge and understanding of existing and needed conditions and services. To improve and add to the relevance and integrity of this information, agencies should increase their ability to collect and incorporate perspectives of those who use the health care system of services, including parents, youth, and providers. Local and state public health assessment participants reported that technical assistance, training, funding, and other resources were needed to build constituency and partnerships, to evaluate and report on program or intervention effectiveness, and to improve the quality, availability and accessibility of health services locally and across Oregon. Local participants, concerned with the lack of available and accessible mental health preventive and treatment services, repeatedly expressed the need to improve the public health infrastructure to adequately address the health needs and disparities of the high risk populations of their communities.

Across all the Essential Services assessments, the following were consistently identified as strengths:

#1: Assess and monitor health status
#2: Investigate health problems & hazards

#6: Promote and enforce health policies

Participants generally agreed that these areas were perceived as strengths because of extensive funding and resources, particularly federal emergency preparedness funding and fee-supported enforcement programs. Information is regularly published and distributed among public and private health providers regarding communicable disease prevention and treatment and health statistics are compiled and published widely. In maternal and child health practice, the strengths identified were focused on the high quality of the individual employees and leadership involved in delivering and coordinating services. Collectively, the MCH workforce feels a need for more training and support to adequately address community health problems and improve service delivery. The positive perceptions of the individuals in the MCH workforce present an opportunity to build support for the activities needed to improve the overall infrastructure.

5. SELECTION OF STATE PRIORITY NEEDS

The selection of health priority needs began with a review and evaluation of work conducted by other offices and agencies during 2004-05. The Local Public Health Agency Plans, the CCF Plans, and other similar documents were reviewed and compiled to determine the highest priority issues felt by Oregon communities. The information from these documents was synthesized to develop the leading priorities most recently assessed by local agencies. A list of health topics was identified as leading problems or assets for Oregonians. (Appendix 8 - Topic Chart) These topics are:

- Insurance coverage and access to care
- Perinatal care
- Mental and emotional health
- Substance abuse
- Injury
- Oral health
- Obesity and nutrition
- Health disparities
- Prevention and screening
- Reproductive health
- Chronic disease prevention
- Other: communicable disease, environmental health, geriatrics

From these issues, overall priorities for Title V were discussed and prioritized among work groups formed around MCH populations. Participants in these sessions were program staff from state public health offices with common interests and knowledge in the MCH population outcomes. Each group organized by population (women, children, adolescents, and children with special health needs) and participants were provided with data information packets. A two-step prioritization process resulted in “aims” for each population group. An aim is similar to a goal but it is measurable and active, and is

intended to serve as an over-arching focus for performance or outcome measures. Criteria for the aims included:

- *Importance:* Based on health status indicator data, does the health topic significantly impact a large number or of a vulnerable sub-population of Oregonians (health disparity)?
- *Ability to Impact:* Can the health topic be improved upon in 5 years?
- *Measurability:* Can we measure the impact that we make?
- *Leverage:* Do current opportunities or resources (such as current efforts or initiative, funding, public awareness or political will) exist to leverage the impact of working on the topic?
- *Alignment with State Agency Priorities:* Does work on this topic promote and/or support the governor's and/or other state agencies goals and policy agendas?
- *Alignment with Other Partners' Priorities:* Does work on this topic address an issue of stated importance to our Local Health Departments or other partners?
- *Impact on OFH programs:* Will working on the topic build, expand, or shift the current work of OFH programs in a direction consistent with our values and mission?

The aims were organized by category to illustrate that most of the aims cut across all populations. (Appendix 9 - Aims by Category). Participants in the Leadership Group meeting then ranked the aims within each category. Six aims received the top votes:

* Children's health needs are always met.

* Individuals and families exhibit healthy lifestyles.

* Children, adolescents and families experience optimal mental health and social emotional development.

* Parents and providers are confident in caring for children.

* Racial and ethnic disparities are eliminated (cross-cutting)

* Strong leadership is helping to reduce morbidity and mortality of the maternal and child health population (cross-cutting).

The last two were identified as cross-cutting that apply to all other aims and the MCH population groups. These priorities will be reflected in demographic health status indicators for most of the performance measures and will be addressed when planning activities and strategies.

A "Matrix of Change" for each aim (Appendix 10 – Worksheets) captured the brainstorm of thoughts and ideas of the participants about needs, interventions, strategies, partners, and measures for to select Title V state performance measures and to plan for the next

steps in addressing these issues. The MCH Epidemiologist and research analyst team developed performance measures, with valid, reliable data sources. The Leadership Group then reviewed all the possible measures, clarified the priority aims, and selected the best measures for the OFH and CDRC Title V Programs.

Below is a summary of the Aims, State Performance Measures, Populations, and a brief summary of activities by Title V Pyramid level. More research, discussion and planning is expected to expand and implement activities that will influence the performance measures.

PRIORITY 1: CHILDREN'S HEALTH NEEDS ARE ALWAYS MET

- ***Improve early child development and access to early intervention services as measured by the percent of infants diagnosed with hearing loss that are enrolled in early intervention before 6 months of age.***

  Measure: the percent of infants diagnosed with hearing loss that are enrolled in Early Intervention before 6 months of age

  Populations: Infants, Children, Children with Special Health Needs

  - *Direct and Enabling:* Oregon's Early Hearing Detection and Intervention (EHDI) Program conducts follow-up on infants, who are at risk or have been diagnosed with a hearing loss, to ensure they are enrolled in Early Intervention prior to 6 months of age. The EHDI Program has established protocols to educate and assist parents and health care providers directly to help ensure infants receive timely diagnosis and intervention. These protocols include direct referral to Early Intervention, as well as referrals to local public health departments to assist families in receiving needed services.
  - *Population-based:* The EHDI program has developed a Newborn Hearing Registry and Tracking and Follow-up database system to ensure that all Oregon births receive a newborn hearing screening with appropriate follow-up diagnostic and early intervention services. The EHDI program has been able to use data from the system in determining the number of Oregon infants meeting the national EHDI goals of screening by one month of age, diagnosis by three months of age and early intervention by six months of age.
  - *Infrastructure:* The OFH and CDRC work together with the Newborn Hearing Screening Advisory Committee to assess program and policy needs to support the EHDI process in Oregon. The OFH and the Oregon Department of Education, Part C Program, work together to assure coordinated, family-centered programs are available and accessible to infants, who are deaf and hard of hearing, and their families.

- ***Improve the access of well-child care as measured by an increase in the percent of children that complete the 4th DTaP vaccine between 12-18 months of age.***

  Measure: Percent of children that complete the 4th DTAP vaccine (12-18 mos)

  Populations: Infants, Children

- *Direct and Enabling*: Oregon Immunization Program links children to providers to receive their 4th vaccine with the intent to assure children aged 12 -18 months receive a well-child visit. The ALERT immunization registry has a website for providers to check their patients immunization status.
- *Population-based:* The Immunization Program tracks immunization status through Oregon's ALERT registry and the NIS. Current data shows a sharp drop in 4th DTAP vaccine statewide, and an increase in pertussis disease. Interventions and strategies will be integrated in early childhood health and childcare programs.
- *Infrastructure:* The OFH Title V programs will develop state-level partnerships and strategies to help assure children aged 12 – 18 months receive a well child visit, including education about 4th DTaP within its programs such as WIC, Hi-Risk Infant Tracking, Child Care Consultation, and Maternity Case Management. Expansion of quality improvement methods within these programs will be developed to evaluate on-going effectiveness of interventions.

➢ ***Decrease the percent of 11th graders who report having unmet health care needs***
Measure: Percent of 11th graders who report having unmet health care needs
Populations: Children and Adolescents

- *Direct and Enabling:* OFH, Adolescent Health Program provides services and resource for statewide development of school-based health centers and facilitates a statewide coordinated school health coalition, "Healthy Kids Learn Better" to promote increased access to primary care, mental health and safety net services to adolescents and youth.
- *Population-based:* The OFH Adolescent Health Program works with the Oregon Department of Education to implement the Healthy Kids Learn Better Program, local school demonstrations projects that implement the coordinated school health systemic change model to addressing specific health conditions or issues that are barrier to learning and success.
- *Infrastructure:* On-going capacity and assessments of county health departments is occurring to determine needs in building and improving adolescent health promotion locally. Ongoing assessment of school needs and capacity related to health and mental health services. Ongoing certification of School-Based Health Centers including training and quality assurance functions.

PRIORITY 2: INDIVIDUALS AND FAMILIES EXHIBIT HEALTHY LIFESTYLES

➢ ***Improve oral health by increasing the percent of Oregonians living in a community where the water system is optimally fluoridated***
Measure: Percent of Oregonians living in a community where the water system is optimally fluoridated
Populations: Infants, Children, Children with Special Health Needs, Pregnant Women

- *Direct and Enabling:* Oregon Oral Health Advisory Committee, Fluoridation Task Force is actively engaged in advocating fluoridation of community water systems across Oregon.
- *Population-based:* The Oral Health Program has developed surveillance of early childhood oral health through surveys which will track the incidence of cavities in young children over time.
- *Infrastructure:* The Oral Health Program will be implementing its statewide plan in the next year or two, including providing technical assistance and consultation to communities to implement local oral health improvement projects. Statewide and community coalitions are formed or being formed to educate and advocate about fluoridation.

➢ ***Reduce low birthweight and improve the health of women and their newborns by increasing the percent of smoking pregnant women who quit smoking during pregnancy and continued quit after pregnancy.***

Measure: Percent of smoking pregnant women who quit smoking during pregnancy and remained quit

Populations: Pregnant Women, Infants

- *Direct and Enabling:* The Oregon Maternity Case Management (MCM) and BabiesFirst! (BF!), a hi-risk infant home visiting and case management service, providing Public Health Nurse smoking cessation services to smoking pregnant women and mothers of infants and young children using the evidence based and ACOG recommended Five A's smoking cessation protocol.
- *Population-based:* following a 3 ½ year demonstration project to increase provider use of the Five A's smoking cessation intervention with smoking pregnant women. The project resulted in a significant increase in the use of the intervention among the nurses and the public health agencies for which they work and an increase in their confidence to assist smoking pregnant women to stop smoking.
- *Infrastructure:* As a result of the success of the project OFH has incorporated the model throughout the statewide MCM & BF! Programs. OFH Nurse Consultants and contracted providers provide training and technical assistance in the use of the Five A's protocol for Public Health Nurse providers of Maternity Case Management services and BabiesFirst! Services, as well as other health care providers throughout the state. In addition, the OFH Nurse Consultants provide technical assistance and on-going needs assessment to county health departments and their partner providers, to assure continued and accurate use of the 5A's protocol for smoking cessation.

➢ ***Improve the health of children and families as measured by the percent of births that are intended.***

Measure: Percent of births that are intended

Populations: Infants, Children, Adolescents

- *Direct and Enabling:* OFH Programs provide extensive client education in contraception and birth planning through its county-based programs in Family Planning, Maternity Case Management, and Babies First!, a hi-risk infant home visiting and case management service.
- *Population-based:* Through PRAMS survey data, surveillance of intended births is ongoing and informs providers, stakeholders and OFH programs.
- *Infrastructure*: OFH programs provide training, technical assistance, and needs assessment to stakeholders and partners who are implementing best practices in contraception.

➢ ***Increase the percent of adolescents engaging in physical activity as measured by the percent of (8th and 11th) graders who report 3 or more days of vigorous physical activity in the last 7 days.***

Measure: Percent of (8th and 11th) graders who report 3 or more days of vigorous physical activity in the last 7 days
Populations: Children, Adolescents

- *Direct and Enabling:* Children and adolescents receive nutrition and physical activity screening and health promotion services at Coordinated School Health sites, School-Based Health Centers, and local health departments. The OFH, Adolescent Health Program provides resources and technical assistance in the implementation of these services. .
- *Population-based:* Oregon Adolescent Health Program in OHF assists in implementation of programs that promote reduction of sedentary lifestyles, such as Walk or Bike to School, TV Turn-Off, and with the development and dissemination of consistent heath messaging related to nutrition and physical activity.
- *Infrastructure*: OFH, Adolescent Health Program provides resource development to Coordinated School Health sites, School-Based Health Centers, and Local Health Departments to increase nutrition and physical activity education, screening and services. The Adolescent Health Program participates in statewide training, planning and assessment efforts related to physical activity and nutrition including Healthy Kids Learn Better, Juvenile Obesity Group, Active Community Environments.

PRIORITY 3: PARENTS AND PROVIDERS ARE CONFIDENT IN CARING FOR THEIR CHILDREN

➢ ***Improve the care of children with special health needs by increasing the percent of health care providers who report confidence in caring for CYSHN and their families***

Measure: Percent of health care providers who report confidence in caring for CYSHN and their families.
Populations: Infants, Children, Children with Special Health Needs

- *Direct, Enabling and Population-Based:* Activities to be planned.

- *Infrastructure:* OCSHN program will develop and provide interdisciplinary training for health care professionals from a variety of disciplines (medicine, nursing, psychology, social work, and nutrition) to become effective clinicians with advanced skill level and health knowledge for the improvement of the health of children with special health care needs and their families in Oregon. These training activities include CaCoon nursing training and ongoing CCN consultations and site visits.

- ***Improve access to care for children with special health needs by increasing the percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.***

  Measure: Percent of families of SYSHN who report costs not covered by insurance were usually or always reasonable.
  Populations: Infants, Children, Children with Special Health Needs

  - *Direct and Enabling:* OSCSHN Family Support Program will assist families with out-of-pocket expenses, transportation arrangements. The Family Support Program advisory committee will continue ongoing review of family needs and program effectiveness. The committee will track fund utilization, consider exceptional requests for support needs that are outside program parameters and review other issues. Coordination of FSP, Zetosch and other foundation or private funds will continue to maximize opportunities for support of CYSHN and their families.
  - *Infrastructure*: OSCSHN will continue to build a state coalition on adequate financing of needed services, include training on benefits advocacy in State-wide annual conference, partner with the coalition in the completion and maintenance of health care finance asset map for Oregon and recruit legal representation for the state coalition to guide our efforts on benefits counseling and managed advocacy

- ***Increase the percent of families of CYSHN who reside in rural areas who report that needs are usually or always met.***

  Measure: Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.
  Populations: Infants, Children, Children with Special Health Needs

  - *Direct and Enabling:* OSCSHN will continue to support the Promatora program in 4 counties serving monolingual Hispanic families with access to health care and other services
  - *Population Based:* Activities to be planned.
  - *Infrastructure:* OSCSHN will collaborate with ORPRN practices and CCN physicians and add parent participation with the goal of hiring parents who reflect the diverse cultures in those communities. These parents will work with CaCoon nurses to identify cultural resources and brokers through a process of community asset mapping in rural communities and adding local resources

including dental, mental health and youth transition resources to the resource guide on the OSCSHN web site.

PRIORITY 4: CHILDREN, ADOLESCENTS AND FAMILIES EXPERIENCE OPTIMAL MENTAL HEALTH AND SOCIAL EMOTIONAL DEVELOPMENT.
Developmental: Mental Health and Social Emotional Development
Populations: Pregnant Women, Infants, Children, and Adolescents

A clear message from the Title V Needs Assessment related to the need for increased focus on the area of mental health – both for women and children. Perinatal and post-partum depression, infant mental health, social/emotional development of young children, adolescent mental health, and the capacity of the mental health service system were all areas of concern. The Office of Family Health currently has some focus on these topics through our existing women, children and adolescent health programs. However, the Office recognizes the need to increase and prioritize the development of a more integrated and comprehensive system to link mental health and public health services for the MCH population. At this time however, the availability of a reliable data source, as well as clear development of program activities, preclude the ability to develop a Title V measure related to mental health improvement.

Therefore, over the next 5 years the OFH will prioritize development of an infrastructure to address mental health and social emotional development needs within the MCH population – both through Title V services and through linking with partners in the mental health system. The work will be pursued through current activities such as: the Early Childhood System Development initiative, expansion the Childcare Health Consultant initiatives into mental health, and training of public health nurses in social/emotional development. We are also committed to developing the data sources needed to measure our efforts to strengthen metal health and social/emotional development of women and children. We anticipate developing a performance measure for mental health to include in the next 5-year Title V Plan.

Priorities across all populations and performance:
The following priorities were selected and maintained as a Title V priority without specific performance measures, because the issues they represent are critical toward accomplishment across the other priorities.

Priority 5: Racial and ethnic disparities have been eliminated.
Disparity and demographic data is available for many of the Title V and other performance measures. These measures will be developed, monitored, and documented through MCH Block Grant reporting. Planning program designs and evaluations will include specific information and interventions effectively reduce racial and ethnic disparities.

Priority 6: Strong leadership is helping reduce morbidity and mortality of the MCH and family population.

Capacity assessment information clearly highlighted the need for Oregon's Title V public health programs to enhance its leadership role, especially in relation to county health department programs and public health nursing. Services identified for improvement included expanding collaboration systems, increasing program evaluations, and preparing and using available data information for state and community profiling and advocacy. In planning activities to meet the goals of the MCH priorities, these capacity areas will be addressed, with the development and monitoring of organizational and process performance measures.

6. NEEDS ASSESSMENT SUMMARY

Summary of the process

The 2005 Oregon Needs Assessment process incorporated several paths of data collection and analysis, and synthesized multiple assessments conducted by MCH programs, the state public health system, and local public health systems. The OFH took advantage of recent local plans, evaluations and existing meetings to solicit input and select priorities. Extensive research of current health status indicators for population groups and priority issues supports the assessment findings.

The Office of Family Health will follow through with development of plans and strategies and further investigate community needs to identify the best community and family-based practices and interventions. The OFH will also be strategizing actions that will build capacity in collaborations and quality improvement. These activities will be shared with the Oregon Children and Youth with Special Health Needs (OCYSHN) program at the Child Development and Rehabilitation Center.

Changes since last needs assessment

Oregon continues to implement activities and monitor performance measures for priorities identified five years ago. During this time, Oregon and the MCH program has experienced reductions in federal, state, and local resources, including workforce capacity, as well as increases in health disparities and population risk factors, such as poverty, unemployment, health insurance access, and substance addiction. In spite of these challenges, Oregon has made positive progress in priorities for oral health, early developmental screening, integration of mental health and public health strategies, and access to prenatal care for all women.

The new proposed state performance measures include two measures from the previous assessment that have been reworded: increase births (rather than pregnancies) that are intended and increase smoking cessation among pregnant women (rather than births whose mothers abstained from tobacco). These changes are the result of improved quality of data sources to monitor these health indicators. The performance measure to increase communities with fluoridated water systems will continue as this oral health issue continues to be a high priority and has gained momentum in communities. The CSHCN measure to increase care coordination uses improved data sources to more specifically measure the confidence that providers care for CSHCN children, a key indicator that these children will receive adequate care coordination for their health needs. This measure is more directly related to CDRC activities.

The 2005 needs assessment focused on capacity to assess the perception that the Oregon public health system performance of the ten Essential Services Standards was not keeping pace with the health needs of the population. The findings of this assessment, along with the MCH priorities, are comprehensive in its findings to improve both health status and public health capacity.

Needs analysis and overall findings

The Title V Needs Assessment findings include both capacity and health status priorities. The State's Title V Performance Measures for 2006-2011 reflect needs of the MCH populations. Planning activities will focus on meeting the health status goals and improving overall program capacity and performance. Below is a summary of the capacity and health status needs, followed by tables that compare the current priorities and performance measures with Oregon's updated priorities and performance measures.

Capacity Needs:

- Data information needs to be analyzed and available to create state and community health profiles and used in policy development and advocacy
- Collaborations with health providers, social services, community organizations and family representatives need to be expanded and incorporated in OFH program and policy activities
- Program evaluation and quality improvement systems are needed to measure effectiveness of programs and interventions and to support decisions regarding program design and resource allocation
- Local MCH programs need to improve their ability to advocate for community health needs, which requires state supported technical assistance, training, and resources
- MCH state and local leadership needs to be enhanced in order to address and advocate effectively for health issues facing communities and MCH populations

Health Status Needs:

- Access to health care is needed by all populations, including access to health insurance coverage and health providers in rural areas
- Developmental screening and early intervention needs to be universally practiced by providers and care givers and available for young children and families
- Prevention and management of chronic health conditions needs to be available to families through community and individual education and care coordination
- Emotional development and mental health support needs to be integrated with public health programs and services for children, adolescents, pregnant women and their families
- Health disparities need to be addressed in MCH service design and delivery to truly improve the health status of Oregon's diverse populations

Current 2001-2006 Priorities	Current 2001-06 State Performance Measures
• Increase Early Quality Prenatal Care • Reduce Child Abuse and Neglect • Promote Adolescent Mental Health and Substance Use Prevention • Improve Oral Health Systems • Reduce Intimate Partner Violence	1. Percentage of all pregnancies among women 15-44 that are intended.
	2. Percentage of women taking a multivitamin with folic acid most days prior to becoming pregnant
	3. Percentage of pregnant women with a live birth during the year who abstained from using tobacco during the pregnancy
	4. Seat belt/car seat use: Percentage of children aged 0-4 years observed to be properly restrained
	5. Percentage of 8th grade students who report using cigarettes in the previous month
	6. Percentage of population living in a community where the water system is optimally fluoridated.
	7. Percentage of K-12 students who have access to a School-Based Health Center
	8. Percent of CSHCN in Oregon receiving appropriate care coordination services
	9. Degree of participation in the collaborative effort of developing a statewide data system to support Oregon's early childhood program needs.
	10. Percent of providers in Oregon participating in an educational experience addressing CSHCN

NEW 2006-2011 Priorities	NEW 2006-11 State Performance Measures
* Children's health needs are always met * Individuals and families exhibit healthy lifestyles * Children, adolescents and families experience optimal mental health and social emotional development * Parents and providers are confident in caring for children * Racial and ethnic disparities are eliminated (cross-cutting) * Strong leadership is helping to reduce morbidity and mortality of the maternal and child health population (cross-cutting)	1. Percent of births that are intended
	2. Percent of infants diagnosed with hearing loss that are enrolled in early intervention before 6 months of age
	3. Percent of children that complete the 4th DTaP vaccine between 12-18 months of age.
	4. Percent of smoking pregnant women who quit smoking during pregnancy and remained quit
	5. Percent of 11th grades who report having unmet health care needs
	6. Percent of (8th and 11th) graders who report 3 or more days of vigorous physical activity in the last 7 days.
	7. Percent of Oregonians living in a community where the water system is optimally fluoridated.
	8. Percent of health care providers who report confidence in caring for CYSHN and their families
	9. Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.
	10. Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.

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Binge drinking is defined as having 5 or more drinks of alcohol in a row, within a couple of hours on one or more days.

[149] Binge drinking is defined as having 5 or more drinks of alcohol in a row, within a couple of hours on one or more days.

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Oregon Title V Needs Assessment Leadership Group

The Leadership Group is responsible for assuring the assessment product is focused on the priority issues, the work is staffed appropriately, program resources are designated to support activities if needed, and is invested in the resulting strategic plan. This group will be making decisions regarding project direction, accountability, and resource allocation.

The State Leadership Group includes:
Donalda Dodson, Executive Leader for project (Office Administrator, Title V Director); after Dec. 2004: Katherine Bradley
Molly Emmons, Project Manager
Isabelle Barbour, Project Staff
Office of Family Health Section Managers:
Jeanne Atkins, Women's and Reproductive Health*: Sue Woodbury*, WIC; *Lorraine Duncan*, Immunization; *Pat Westling*, Perinatal Health and Oral Health; *Bob Nystrom*, Adolescent Health and Genetics; *Claudia Bingham*, Child Health;
Office of Disease Prevention and Epidemiology: *Lisa Millet*, Injury Prevention
Child Development and Rehabilitation Center: *Cathy Renken* and *Robert Nickel, MD, Marilyn Hartzell*.
Consultant managers: *Ken Rosenberg, MD*, Medical Epidemiologist, *Jim Gaudino, MD; Sherry Spence*, MCH Data Coordinator, *Eve Pepos*, Data Coordinator, *Beth Epstein, MD*, Medical Consultant
Marti Franc, Clackamas County MCH Director and Chair, MCH Committee of the Conference of Local Health Officials

Oregon MCH and Family Health Services
FIVE YEAR NEEDS ASSESSMENT

Goal:

Develop a plan of interventions based on the assessed strengths and needs of Oregon's women, children and families, and the health infrastructure that serves them.

Purpose:

The purpose of the needs assessment is to use findings and recommendations of a comprehensive needs assessment to strengthen the ability of the Office of Family Health and its partners to prioritize and respond to public health issues.

Values:

We value:

- Individuals in the context of families and communities
- Physical, psycho-social, spiritual, and emotional health
- Evidence-based practice in program development
- Qualitative and quantitative problem identification
- Continual improvement for systems and services
- Community and professional partnerships
- Diversity and cultural competency
- Comprehensive and coordinated care, services, and systems
- Safe communities

Project Objectives:

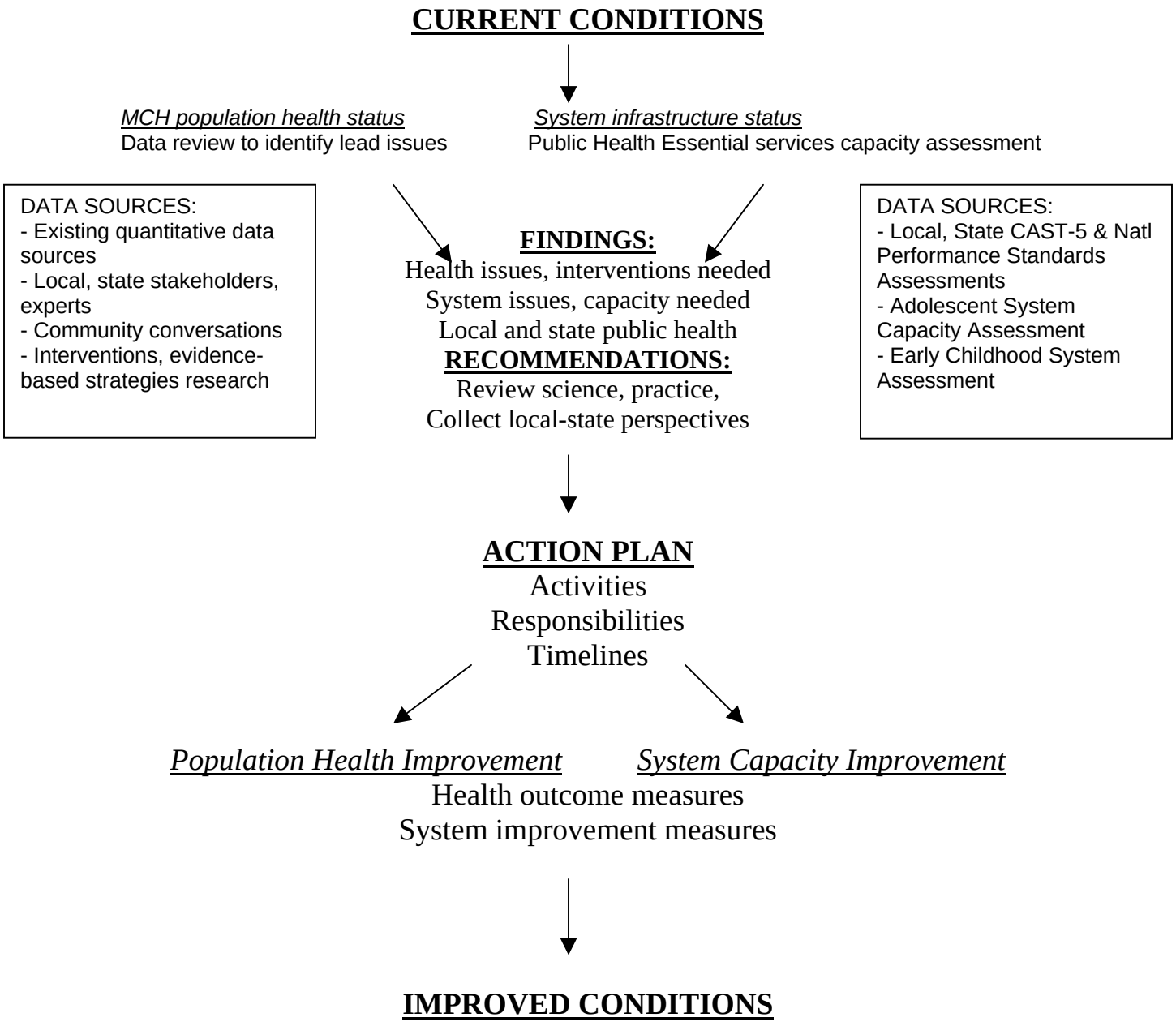
Create a plan for the Office of Family Health and Oregon Title V Programs through a comprehensive community-based needs assessment

1. Identify statewide leadership, champions and investors to support the assessment findings, recommendations, and strategic plan
2. Compile and synthesize existing data for MCH populations to identify leading health issues and baseline monitoring information
3. Engage local and statewide community partners and stakeholders in assessment and planning
4. Assess health system capacity to provide adequate, accessible services
5. Identify intervention strategies that support positive community health outcomes
6. Utilize innovative, best and evidence-based practices for state and local implementation
7. Develop outcome and performance measures based on identified priorities

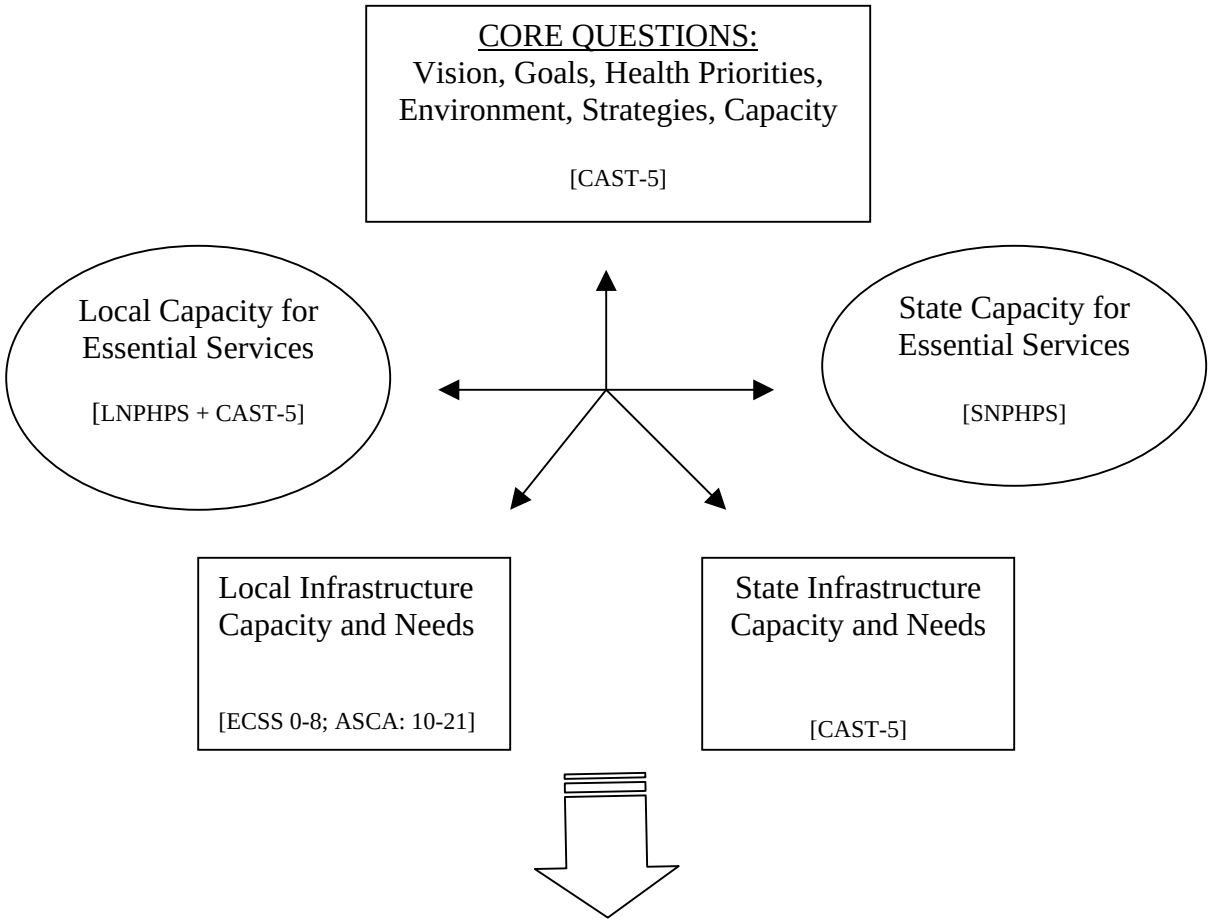
Complete a five-year strategic action plan for Office of Family Health and Title V programs and services

Office of Family Health – MCH Five-Year Needs Assessment

Template for Assessment and Plan



CAPACITY ASSESSMENTS FOR MCH NEEDS ASSESSMENT[1]

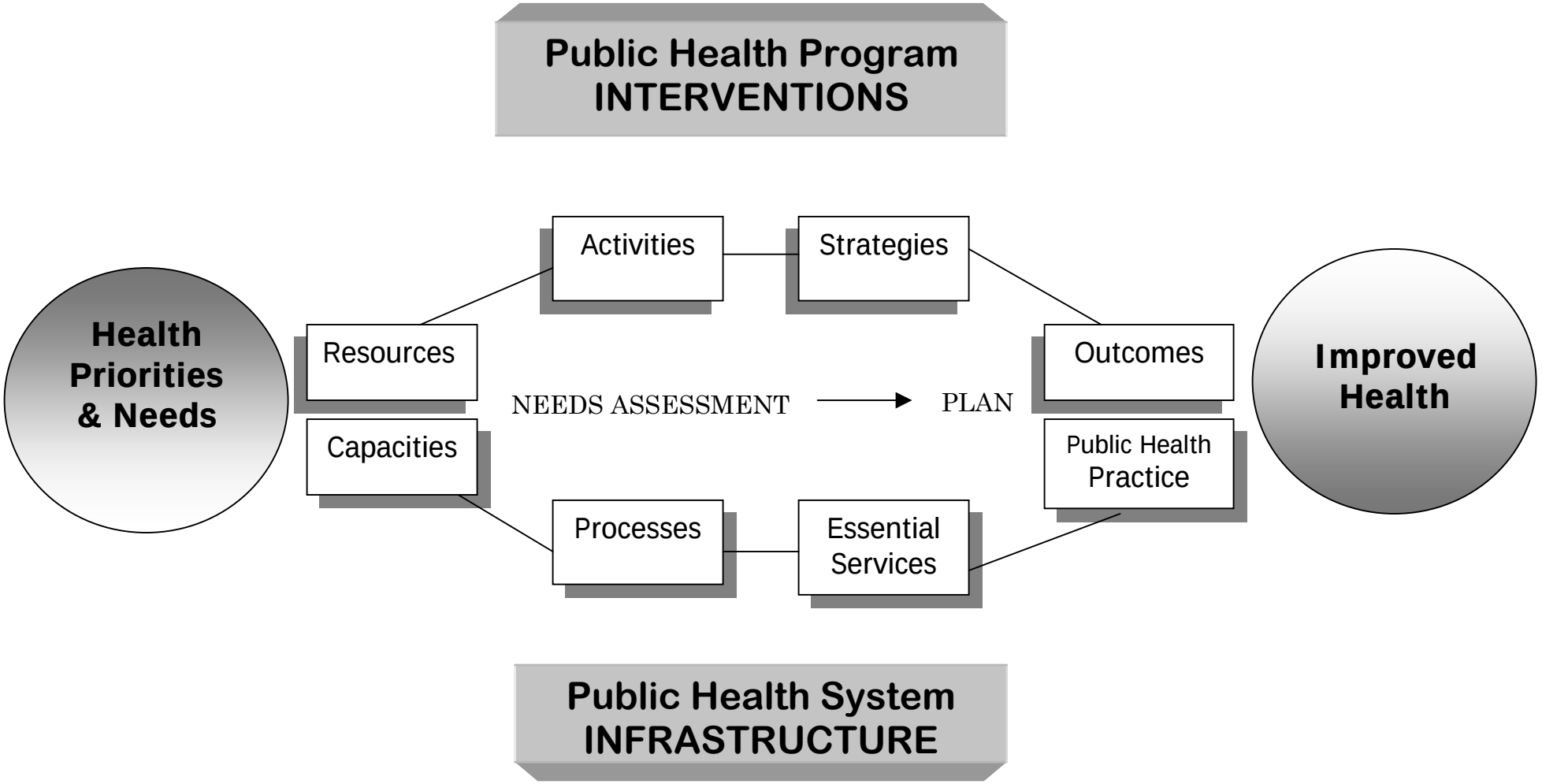


[1] LNPHPS: Local National Public Health Performance Standards Assessment – completed Spring 2004
SNPHPS: State National Public Health Performance Standards Assessment – completed June 2004
CAST-5: Capacity Assessment for State Title V Programs – proposal to coordinate with NPHPS assessments
ECSS: Early Childhood Services System Planning Project – assessment of services capacity for ages 0-8 population
ASCA: Adolescent System Capacity Assessment – assessment of services capacity for ages 10-21 population

Add Logic Model Here

Office of Family Health – MCH Five-Year Needs Assessment

LOGIC MODEL FOR PUBLIC HEALTH ASSESSMENT AND PLANNING



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DHS-OFH 7/6/2004

State of Oregon Office of Family Health –
County Health Plan *Unmet Need* Review- Nov. 2004

Oregon county health departments have submitted Local Public health Improvement Plans to the DHS, Health Services, Office of Community Health, in May of each year. The plans include each county's priorities, goals, objectives, activities and unmet needs. As part of the Five-Year Needs Assessment, the Oregon Office of Family Health conducted an analysis of the "unmet needs" listed in the county plans submitted in May 2004. The goal of this analysis was to identify the most common needs facing women, children and families across Oregon. This information serve as a basis for further needs assessment, goal setting, and planning by Office of Family Health programs.

Thirty-five health departments represent the 36 counties in Oregon. Thirty-two county plans were used for this analysis. Wherever possible the most recent version of each county plan was used. The 2004-2005 County plans were used for the overwhelming majority of counties. For a small number of counties, current plans were not available for these few counties 2003-2004 plans were examined. County plans could not be found for three counties. A spreadsheet containing notes for the analyzed county plans can be found in Appendix I.

There was a great deal of variation in the care used by the county personnel who wrote the executive summaries and unmet needs sections of the plans that were analyzed. This analysis is not intended to serve as a scientific, irrefutable proof of what all Oregonian counties need. It was created to assist in program planning and to identify policy directions for the Office of Family Health and partners.

The chart below shows the top ten most commonly mentioned unmet needs contained in the analyzed plans.

Rank **Topic**

1 **Un or Under- insured.**
A lack of insurance, or an inability for clients to afford deductibles and co-pays was the most frequently mentioned need. Several counties wrote about the negative impacts of changes that had been made to the Oregon Health Plan (OHP). Counties also reported that providers were not taking OHP clients. Lack of adequate insurance was cited by the counties as a decisive barrier between Oregonians of all ages and primary care, mental health services, and dental services.

2 **Disparity in health outcomes or health services available to racial, ethnic, or linguistic groups.**
This topic includes the following set of issues in order of frequency: a need for services directed towards the Hispanic population/health services delivered in Spanish, the health

Rank **Topic**

needs of undocumented individuals, Hispanics suffering worse health outcomes than the population as a whole, a need for health services for immigrants.

3 **Prevention Programming- Variety of Topics**
Counties stated a need for resources to offer prevention programming around a wide variety of topics including, cancer, chronic disease and West Nile Virus.

4 **Geriatrics**
A large number of needs were listed for this population including but not limited to: dentures, eyeglasses, hearing aides, long term care, and assistance with activities of daily life.

5 **Tobacco Use**
Counties blamed cuts to tobacco funding for an increase in tobacco use. Counties stated that they had needs for both cessation and prevention resources.

6 **Women's Reproductive Health**
The two most common issues comprising this topic are: 1) A lack of Obstetric providers in the county, 2) A lack of adequate prenatal care resources for pregnant women in the county. Other issues mentioned include pregnant women abusing alcohol, tobacco, and other drugs and a need for increased CAWEM and WIC resources.

7 **Dental Insurance as a Barrier to Receiving Oral Health Care**
Dental insurance was named independently of other types of health insurance as a need by the counties. Lack of dental coverage under OHP was cited as a specific barrier to oral health faced by low-income residents.

8 **Mental Health**
Counties listed mental health services for the general population as a need for their residents.

9 **Alcohol and Other Drugs**
Alcohol and other drug counseling and treatment services for the general population was listed as a need by counties. This need was often linked to a lack of mental health services in the county.

10 **Dental Services/Providers**
Counties cited a lack of dental services and providers as a major source of need.

A note on how this list was created:

For the purpose of conducting this analysis a lengthy list of needs specified by the counties was created. A count was then taken of the number of counties that mentioned each need. Counties may have mentioned one need five times – but the count only measures the number of counties that listed the need- not the total number of times the need was mentioned. Occasionally one topic has been counted twice, one time in two categories, for example a county that specifies that they need help to address domestic violence in their community would receive one count under the topic domestic violence and one count in the general intentional injury category (the intentional injury category is an aggregation of a number of types of intentional injury). To create this top ten list aggregated topic areas were not used with the exception of the *Disparity of Health Outcomes or Service* and the *Women's Reproductive Health* topics.

OFFICE OF FAMILY HEALTH
Maternal and Child Health Indicators
July 2005

Infants & Young Children (0-5 year)

INSURANCE

- In 2003, 12% of Oregon children age 0-3 were uninsured. This is twice the national rate of 6% for this age group.[1]

- An additional 10% of Oregon children 0-3 were not insured at some point during the 12 months prior to being surveyed (compared to 6% nationally).[2]

- In 2003, government sponsored healthcare programs insured 26% of Oregon children age 0-3, 5% less than the national average.[3]

- In Oregon, in 2003, 37% of infant's births were paid for by public health insurance and 58% were paid for by private insurance. [4]

Note

- More Oregon children were uninsured and fewer are covered by public insurance (i.e. Medicaid) than the national average in 2003.

- Nationally almost 30% of all children under the age of 6 visited the emergency room at least once in the past 12 months.[5] Those children that had Medicaid insurance (38%) were more likely to visit the emergency room than those that had private insurance (25%) and uninsured children (22%).[6]

MENTAL/EMOTIONAL HEALTH

- Six percent of Oregon parents identified their 0-3 year old as having difficulties with emotions, concentration, behavior, or difficulty getting along with others (compared with 8% nationally).[7]

- Eight percent of Oregon parents of 4-5 year olds identified these difficulties in their children (compared to 12% nationally).[8]

Note

- Fewer Oregon parents report social/emotional health concerns than the national average. [9]

EXPOSURE TO SUBSTANCE USE AND ABUSE

Tobacco

- In 2003, 12% of Oregonians who gave birth reported using tobacco while pregnant.[10] This finding meets the 2005 DHS Performance target of 12%.

- In 2001, 16% of Oregon mothers with 6 month olds were smoking at least 1 cigarette a day and 27% of them said that there was another person in the house that smoked cigarettes, pipes, or cigars.[11]

- Ninety-six percent of all PRAMS respondents in 2001 said that no one was allowed to smoke in the home.[12]

Note

- Since 1999 the percentage of women that smoked during pregnancy has decreased from about 15% in 1999 to 12% in 2003.[13]

- Women under 25 are twice as likely to smoke during pregnancy as those 25 or older, 20% in the younger group compared to 6% in the older group. [14]

Alcohol and Drug Abuse

- According to a 2003 report, alcohol and/or drug abuse was suspected to be a factor in 43% of child abuse or neglect cases.[15]

- In 2003, 2% of Oregon mothers reported using alcohol during pregnancy and 1% reported using illicit drugs during pregnancy.[16]

Note

- The portion of women self-reporting that they abstained from alcohol during pregnancy has steadily increased from 95% in 1990 to 98% in 2003.[17]

BIRTH OUTCOME

Low Birth Weight

- In 2003, 6.1 per 1,000 live births in Oregon were low birth weight (<2500 grams).[18] Nationally, 7.8 per 1,000 live births were low birth weight in 2002.[19]

Note

- The rate of live births (including multiple births) in Oregon that were low birth weight was about 5.4 per 1,000 live births from 1996 through 1999, but have since increased steadily to 6.1 per 1,000 live births.[20]

- **Disparity**

In 2002, the national rate of low birth weight infants for African Americans is twice as high as for whites, 13.3 per 1,000 and 6.8 per 1,000 respectively.[21]

Birth Defects and Infant Mortality

- Almost half of all infant deaths (118 of 260) were caused by conditions originating in the perinatal period.[22]

- Among deaths that occurred during the perinatal period, approximately 1/3rd (34) were connected to maternal factors and another 1/3rd (36) were caused by gestation and fetal growth.[23] Fifteen fetal deaths were caused by disorders related to short gestation and low birth weight.[24]

- Sixteen infants were born with Fetal Alcohol Syndrome in Oregon during 2003.[25]

- Infants with mothers that use alcohol during pregnancy have twice the rate of death during the perinatal period[26] compared with infants whose mothers did not use alcohol (11.9 per 1,000 and 5.3 per 1,000, respectively).[27]

- The infant mortality rate in Oregon is 5.8 deaths per 1,000 live births.[28] Our Oregon Benchmark target for infant mortality rate in 2005 is 5.1 deaths per 1,000 and 4.5 by 2010.[29] In 2002, 7.0 infant deaths were reported per 1,000 live births nationally.[30]

Note

- The infant mortality rate decreased substantially from 1990 (8.3 deaths per 1,000 live births) to 1996 (5.6 deaths per 1,000 live births). From 1997 through 2003 the infant mortality rate has fluctuated between 5.4 and 5.8 deaths per 1,000 live births.

- Congenital Malformations, low birth weight and sudden infant death syndrome (SIDS) account for 44% of all infant deaths in the United States.[31]

- In Oregon, congenital malformations accounted for almost ¼ of all infant deaths.[32] In Oregon, SIDS accounted for 31 deaths (0.7 deaths per 1,000 live births) in 2002.[33] Another 9 deaths were caused by accidental suffocation and strangulation in bed.[34]

Note

- Following a national trend, the proportion of Oregon infant deaths attributed to SIDS reduced 20% in 2000 to 12% in 2001 and 2002.[35]

❖ **Disparity**

In Oregon, the infant mortality rate was twice as high for African Americans (9.9 per 1,000) as for whites (5.1 per 1,000).[36] Nationally, the rate of infant mortality for African Americans is even higher, 13.6 per 1,000 compared to 5.7 per 1,000 whites nationally.[37]

❖ **Disparity**

Infant mortality rates are higher for those mothers, regardless of race/ethnicity, who: did not receive prenatal care, are teenagers, had less than a high school education, were unmarried, or who smoked during pregnancy.[38]

INJURY

Abuse

- In 2003, 1,233 Oregon infants under the age of 1 were abused or neglected.[39] There are almost twice as many infant victims under the age of 1 as for any other single year age group up to 18.[40]

- Some of the major problems facing families where child abuse or neglect occur included alcohol or drug abuse (43%), parental involvement with law enforcement (39%), unemployment (35%), and Domestic violence (25%) in 2003.[41]

- In 2003, DHS reported that twenty children below the age of 2 were sexually abused in Oregon.[42]

Unintentional Injury

- In 2003, unintentional injuries are the leading cause of death among children age 1-4 in Oregon, accounting for 27 of 68 deaths in this age group.[43] Of these unintentional injuries, motor vehicle accidents accounted for 10 deaths in Oregon.[44]

- The leading cause of injury related deaths for 0-4 year olds in 2002 was suffocation.[45]

- In 2001, falls are the leading cause for hospitalization for children age 0-4, followed by poisoning and motor vehicle accidents.[46]

- Seventy-six percent of children ages 0-4 in Oregon were properly restrained while riding in cars in 2004.[47]

Note

- Proper use of child car seat restraints for children 0-4 in Oregon has increased from 59% in 1998 to 76% in 2003.[48]

ORAL HEALTH

Oral health Screening

- In 2003, an estimated 15% of Oregon children age 0-3 did not visit a dentist in the past 12 months for any routine preventative dental care (compared to 13% nationally).[49]

- Nationally and in Oregon in 2003, 7% of children age 4-5 did not visit a dentist in the past 12 months for any routine preventative dental care. [50]

Oral Health Care Access

- Twenty-six percent of children age 0-3 in Oregon and nationally in 2003 did not have insurance that helped pay for any routine dental care. [51]

- A 2003 survey found that 29% of Oregon children age 4-5 did not have insurance that helped pay for any routine dental care (compared to 22% nationally). [52]

OBESITY/ NUTRITION

- Information regarding obesity in young children varies substantially by source. Using physician reported data from 1999-2000, 10% of children age 2-5 were reported as overweight (having a body mass index of 95 or higher) nationally.[53]

- Parent reported survey data identified 35% of 2-5 year olds in Oregon as overweight based on BMI compared to 39% nationally.[54]

Note

- Over the past three decades, the rate of obesity has more than doubled for preschool children aged 2 to 5 years and adolescents aged 12 to 19 years, and it has more than tripled for children aged 6 to 11 years.[55]
- For children born in the US in 2000, the lifetime risk of being diagnosed with diabetes at some point in their lives is estimated at 30 percent for boys and 40% for girls if the obesity rates level off.[56]

Body Mass Index calculations have been criticized for not taking frame size or other concerns into account when calculated appropriate weight. The body mass index scale is based on adult heights and therefore may not be the best tool to measure children's appropriate weight, however, this is the most easy to use tool and only tool we have available.

PREVENTIVE AND SCREENING

Prenatal Care

- In 2002, Eighty-two percent of new Oregon mothers received prenatal care beginning in the first trimester. [57] The Oregon Benchmark target is that 85% of new Oregon mothers receive prenatal care beginning in the first trimester.[58]

Note
- The percentage of Oregon baby's mothers that received prenatal care beginning in the first trimester has increased steadily since 1990 when it was at 76%.[59]

Well-Child Visits

- According to the American Academy of Pediatrics, a typical schedule for routine well-child visits would include four visits in the first 6 months of life. Only 18% of Oregon 6-month-old babies received the recommended four visits, and 8% have received one or no well-child visits in their first 6 months.[60]

- Four percent of Oregon children age 0-3 did not have a preventative medical care visit or well-child visit in the past 12 months or since birth (compared to 3% nationally).[61]

- Ten percent of Oregon children age 4-5 did not have a preventative medical care visit or well-child visit in the past 12 months or since birth (compared to 8% nationally).[62]

Note
- Oregon's youngest children receive fewer than the recommended number of preventive care visits, and fewer than their peer groups nationally.

Infant Screening

- In Oregon, 93% of newborns are screened for hearing loss. Unfortunately, about 50% of those that are referred for a follow-up screen do not complete the second screening.[63]

Note
- The percentage of Oregon newborns receiving a hearing screening in the first 30 days of life has increased substantially since first being required by legislation in 2000.[64]

Breastfeeding

- Almost 90% of Oregon mothers are breastfeeding their infants at hospital discharge, compared to only 70% nationally.[65]

- At six months of age, an estimated 50% of Oregon infants are being breastfed, compared to only 33% nationally.[66]

- According to the 2002 PRAMS data, 70% of women were still breastfeeding their infants at 10 weeks of age.[67]

- At 6 months of age, 43% of Oregon infants enrolled in the Women, Infants and Children Program (WIC) were still being breastfeed.[68] Only 22% of infants enrolled in WIC nationally are being breastfed at six months of age.[69]

Note

- Rates of breastfeeding at hospital discharge have steadily risen since 1992 in Oregon.[70] Breastfeeding rates at 6 months of age rose from 34% in 1992, to 50% in 2002. [71]

Medical Home

- In 2003 both Oregon and nationally, 13% of parents of children 0-3 do not have a person they think of as their child's personal doctor or nurse.[72]

- In Oregon, 16% of parents of children age 4-5 did not have one or more persons they thought of as their child's personal doctor or nurse (compared to 13% nationally) in 2003. [73]

Immunization

- Completion of the 4th DTaP by age 2 is a good indication of children receiving all the necessary childhood immunizations and well-child visits. In 2003, an estimated 96% of all children, in Oregon and nationally, received the first 3 diphtheria, tetanus, and pertussis vaccines or DTaP's by age 2.[74] However, only 83% (+/-5.4) in Oregon (and 85% [+/-0.8] nationally) finished the vaccination series with the 4th DTaP by two years of age.[75]

- One of Oregon's DHS Immunization Program's Long Term Objectives is to increase the coverage levels for children age 19-35 months of receiving the 4:3:1 immunizations from the 2001 baseline of 75% (+/-5.7) by 5%. Eighty percent (+/- 5.7) of 2 year olds were adequately immunized in Oregon in the 2003 calendar year according to the 4:3:1 recommendations.[76] Nationally about 82% (+/- 0.9) of 2 year olds were immunized in 2003 according to these recommendations. [77]

- Hospitals used to routinely administer a birth dose of hepatitis B vaccine. In 2003, 39% (+/-6.5) of Oregon infants (compared to 42% (+/- 1.0) nationally), received this vaccination within 2 days of birth.[78]

- In Oregon, 61% (+/- 6.9) of 3 month olds had received their first pneumococcal conjugate vaccine or PCV, compared to 57% (+/- 1.1) nationally.[79]

CHRONIC DISEASE

Asthma

- In 2002, 20.7 Oregon children age 0-5 per 100,000 were hospitalized for asthma.

Note

- Since 1998 the number of children hospitalized for asthma decreased through 2001, but jumped from 2000 to 2001.[80]

Middle Childhood (6-9)

INSURANCE

Lack of Insurance

- In 2003, an estimated 15% of Oregon children age 6-9 were uninsured at the time of being surveyed. This is almost twice the national rate (8%) for this age group.[81] An additional 7% of Oregon children age 6-9 were not insured at some point during the last 12 months, compared to 6% nationally. [82]

- Government sponsored healthcare programs insured an estimated 19% percent of Oregon children age 6-9, compared to 24% nationally, in 2003.[83]

- In Oregon, 23% of children age 6-9 lacked dental insurance that helped to pay for routine dental care in 2003, 2% more than nationally.[84]

❖ Disparity

According to a 2001 report, children nationally who are in poverty, foreign born, live in a metropolitan area, or are Hispanic are less likely to have health insurance than children as a group.[85]

Note

- More children in Oregon are uninsured for both Medical and Dental care than nationally.

MENTAL/EMOTIONAL HEALTH

- One in every 5 children and adolescents nationally are affected by mental health problems at any given time. At least 1 in 10 children, have a serious emotional disturbance according to a 2003 report.[86]

- Among parents of Oregon 6-9 year olds, an estimated 18% - both in Oregon and nationally - identified their child as having difficulties with emotions, concentration, behavior, or being able to get along with other people in 2003.[87]

- In 2003, 13% of Oregon parents identified their children as having "difficulties" (as defined above) reported that the mental and emotional health of the child puts a "great deal"[88] of burden on families[89], (compared to 8% nationally).

Note

- Mental health problems are prevalent - affecting approximately 20% of children and adolescents at any given time.

SUBSTANCE ABUSE

Alcohol

- About 1/3rd (32%) of 4th through 6th graders in one Oregon elementary school reported having had a sip of alcohol.[90] However, only 2% of the respondents (6 of 227) had drunk a whole glass of alcohol.[91]

- Twenty-nine percent of Oregon 8th graders had alcohol in the past 30 days at least once.[92] Nationally 36% of 9th graders drank alcohol in the past 30 days.[93]

Note

- The percentage of 8th graders that drank alcohol in the past 30 days has increased substantially from 16% in 1997 to 29% in 2004. Most recently a 4.0% increase in the 8th grade drinking rate appeared between 2003 (25%) and 2004 (29%). [94]

Tobacco

- In a 2004 survey of 4th through 6th graders at one Oregon elementary school 4% of the students reported having smoked a whole or part of a cigarette.[95] For the same year 23% of 8th graders have tried smoking.

Illicit Drugs and Inhalants

- Fourth through 6th graders at one Oregon elementary school self-reported, 2% having smoked marijuana.[96] In 2004, over 10% of Oregon 8th graders reported having smoked marijuana in the last 30 days.[97]

- In 2004, 4% of 4th through 6th graders at one Oregon elementary school, reported having sniffed a substance with the intent of getting high.[98] The same year, over 6% of Oregon 8th graders reported having sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high during the past 30 days.[99]

INJURY

- In 2003, parents of 4-5 year-olds reported almost 12% (both in Oregon and nationally) of their child being injured and requiring medical attention during the past 12 months. [100]

- In 2002, 182.1 per 100,000 children aged 14 years and younger were hospitalized for nonfatal injuries in Oregon. [101] Falls were the leading cause of injury related hospitalizations in Oregon for this age group in 2002. [102]

Unintentional Injury

- In 2003, 33 children aged 5-14 died from unintended injuries in Oregon.[103] Motor vehicle accidents were the leading cause of unintended deaths for this age group in 2003 accounting for 23 of the 33 unintended deaths. [104]

- In 2002, motor vehicle injury was the leading cause of injury related death for Oregon children age 5-14. [105]

Abuse

- Eleven children per 1,000 under age 18 were abused or neglected in Oregon during 2002.[106]

Note

- Reports of child abuse or neglect in Oregon have increased from 26,000 in 1996 to 42,000 in 2003. [107]

Child Death

- In 2003, unintentional injury was the leading cause of death for children age 5-14 in Oregon, followed by cancer, heart disease, congenital malformations, and influenza or pneumonia. [108]

- According to 2001 statistics, Oregon's homicide rate for children 5-14 is approximately the same as the national rate for this age group. [109]

ORAL HEALTH

Oral Health Care Access

- Rates of individuals who lack dental insurance are generally more than twice as high as rates of individuals who lack medical insurance rates. In Oregon in 2003, an estimated 23% of children age 6-9 lacked dental insurance that helped to pay for routine dental care, two percent more than nationally.[110]

Oral health Screening

- In 2003, 6% of Oregon children age 6-9 did not visit a dentist in the past 12 months for any routine preventative dental care, (compared to 5% nationally).

Fluoride

- Fluoridated water helps to protect children's teeth, however only 23% of the Oregonian population is getting fluoridated water. This is the 5th lowest proportion in the nation.[111]

Tooth Decay

- According to a 2000 CDC report, more than half of children aged 5-9 nationally have had at least one cavity or filling according to a report from 2000.[112]

❖ **Disparity**

Children living in poverty are twice as likely to have tooth decay than their more affluent counterparts.[113]

Dental Sealant

- In 2002, 42% of Oregon 8-year-olds had dental sealant on their permanent molars, compared to 23% nationally. The Healthy People 2010 goal for dental sealants for this population is 50%. [114]

OBESITY/ NUTRITION

Overweight/Obese

- In 1999, national statistics identified that 13% of children age 6 -11 were overweight. The CDC identified that the most immediate consequence for overweight children is a feeling of social discrimination, which leads to poor self-esteem and depression.[115]

- Overweight adolescents are more likely to be overweight adults leading to problems including Type 2 diabetes and heart disease.[116]

- A 2003 survey estimated that 26% of Oregon children age 6-9 are considered overweight or having a body mass index of 95 or higher, this is 5.0% less than the proportion of overweight 6-9 year olds nationally.[117] An additional estimated 18% of Oregon children age 6-9 and 17% of children age 6-9 nationally are at risk for becoming overweight (having a body mass index[118] of between 85 and 95).[119]

Hunger

- In 2003, 1 in 20 Oregon households were "hungry" meaning that one or more members of the households went hungry at some point during the year.[120]

Note

- Oregon has had the highest rate of hunger in the nation for 4 of the past 5 years. [121]

CHILDCARE

- In 2003, Oregon had 17 childcare slots available per 100 children under age 13. Oregon's goal is to increase this number to 25 per 100 by 2010.[122]

Note

- The number of childcare slots per 100 children under age 13 has increased between 1992 (15 slots) and 1999 (22 slots), but has decreased to 17 slots in 2003.[123]

- In 2003, about 1/3rd of Oregon children age 4-5 regularly attended some form of childcare.[124]
- In Oregon in 2003 8,162 children were enrolled in Head Start[125] programs; this was only 47% of eligible kids.[126]

POVERTY

- In Oregon in 2003, 22% of children age 0-18 were in poverty.[127] Children living below the poverty line are likely to experience more hardships in their lives than

their more affluent peers. These hardships include: difficulty in school, teen parenthood, and, as adults, less earning power and more unemployment.[128]

- According to the 2000 Census, children living with married parents are much less likely to be in poverty (6.2%) than those living with a single father (16%) or mother (33%).[129]

- In the United States a 1999 report identified that 65% of homeless women and 7% of homeless men have children living with them.[130]

Note
- The percent of children living in poverty in Oregon has decreased from 16% in 1995 to 15% in 2000. The percent of children in poverty nationally has decreased from 21% in 1995 to 16% in 2000.[131]

PREVENTIVE AND SCREENING

Preventive Care

- In 2003, 21% of Oregon children age 6-9 did not have a preventative medical care visit or well-child visit in the past 12 months (compared to only 15% nationally).[132]

- Among Oregon parents of children age 6-9, 20% did not have a person they thought of as their child's personal doctor or nurse (compared to only 14% nationally) in 2003.[54]

Note
- Oregon children are less likely to have a personal health care provider and less likely to receive preventive medical care than their peers nationally.

Immunizations

- The CDC reported that the number of cases of pertussis or whooping cough, which is vaccine preventable, is at the highest level in 40 years. Almost 40% of those cases of pertussis are affecting the age 10-19 population, which until May 2005, was not vaccine preventable in this age group.

- The Oregon DHS Immunization Program has a long-term objective (from SY 2001-2002 through SY 2006 – 2007) to increase coverage/protection levels by 20% for D/T, polio, varicella, MMR, hepatitis B series for seventh graders. In SY 2001-2002 the baseline was 74% and for SY 2004-2005 the rate is 82%.

CHRONIC DISEASE

Asthma

- A 2003 survey reported that 11% of Oregon children age 6-9 had been told by a doctor or health professional that they have asthma, compared to 13% nationally.[133]

Note

- Between 1980 and 1996 childhood asthma has grew substantially, since that time rates have leveled off.[134]

Type II Diabetes

- About one in 200 children age 6-9 in Oregon and nationally report being told that they had Type 2 Diabetes.[135]

Adolescent (10-24 yrs.)

INSURANCE AND HEALTH CARE ACCESS

Lack of Insurance

- During a 2003 survey, 12% of Oregon adolescents age 10-17 were uninsured.[136] Nationally 8% were uninsured. [137] An additional 7% of Oregon adolescents age 10-17 were not insured at some point during the last 12 months, 2% more than nationally (5%).

- Government sponsored healthcare programs insured 14% percent of Oregon adolescents age 10-17, 6% less than the national average.[138]

- In 2003, 36% of Oregon adolescents age 18 to 24 reported not having any kind of health care coverage.[139] The percentage of 18 to 24 year olds without health insurance is almost 10% higher in Oregon than it is nationally.[140]

Note

- From 2000 to 2003 the proportion of children less than 18 who were uninsured increased by 2%.[141]
- Medicaid covered 1 in 4 children under age 18 in Oregon during 2003, up more than 5% since 2000.[142]
- Other types of insurance coverage for adolescents 0-18 have decreased from 2000 to 2003, including employee sponsored coverage (-5%) and individual coverage (-3%).[143]

Financial Barriers to Health Care

- In 2003, one in four (24%) adolescents 18 to 24 said that there was a time in the last 12 months that they needed to see a doctor, but could not because of cost.[144]

- Nine percent of all adolescents' age 18 to 24 reported in 2003 not being able to access medical care when they needed it during the last twelve months. The majority of adolescents that were not able to access care (63%) cited that the main reason they were not able to get medical care was because of the cost, 22% said that they could not receive care because waiting period was too long.[145]

School Based Health Centers/Safety Net Services

- In 2004, 7% of all Oregon students had access to a state-certified school based health center.

Note

- Access to Oregon School Based Health Centers was at its peak in 2000 when 8% of Oregon K – 12 students had access to a center. This access has decreased since 2000 and state funding for School Based Health Centers was cut in 2003-2004. The state funding has since been reinstated.

MENTAL/ EMOTIONAL HEALTH

- Nine percent of 10-17 year olds in Oregon and nationally had an emotional, developmental, or behavioral problem for which their parent believes they need treatment or counseling during 2003. [146]

- In 2003, 21% of Oregon parents and 19% of parents nationally identified their 10-17 year old as having difficulties with emotions, concentration, behavior, or being able to get along with other people.[147]

- In Oregon, 10% of parents that identified their children age 10-17 as having had "difficulties" (as defined above) reported that the mental and emotional health of the child puts a "great deal"[148] of burden on families[149], 11% nationally .[150]

Depression

- During 2004, 46% of all 11th graders reported feeling depressed at least 1 day a week.[151]

Note

- There has been little change in the proportion of 11th graders that felt depressed at least 1 day a week from 2000 to 2004.[152]

Psychosis

- Bi-Polar disorder may be more severe and as common in children and adolescents than adults. One percent of 14-18 year olds nationally met criteria for bi-polar disease or cyclothymia, a similar but milder illness, in their lifetime in an early 1990's NIMH supported study.[153]

- According to the National Institute on Mental Health, schizophrenia affects about 1 in 100 adults and average age of onset is 18 in men and 25 in women.[154]

Suicide

- The rate of death by suicide for 15-24 year olds was 12.6 per 100,000 in 2003.[155]
  .

Suicidal Ideation

- In 2004, 13% of all 11th graders seriously considered attempting suicide.[156] Nationally during 2003 16% of 9th through 12th graders reporting seriously considering suicide.[157]

Note

- About 13% of 11th graders annually reported seriously considering suicide over the 4 years that the Oregon Healthy Teens Survey has tracked this information (since 2001).[158] Nationally, the percentage of 11th graders reporting seriously considering suicide decreased from 24% in 1993 to 17% in 2003, but no change was seen in the percentage of self-reported suicide attempts (9%).[159]

SUBSTANCE ABUSE

Alcohol Use

- In 2004, 45% of Oregon 11th graders reporting drinking alcohol at least once, for non-religious reasons, during the past 30 days.[160] This is the same percentage as the national average for 9th- 12th graders.[161]

- In 2002, 63%[162] of Oregon 18 to 24 year olds drank alcohol in the last 30 days.[163]

Note

- In Oregon, there has been little fluctuation in the percentage of 11th graders that have drunk alcohol at least once during the last 30 days .[164] Nationally, the adolescent alcohol use trend has decreased to match the Oregon trend.[165]

Binge Drinking

- In 2004, 29% of Oregon 11th graders reported that drank in the past 30 days reported binge drinking[166] at least once in the past month, about the same as high school students nationally in 2003 (28%).[167]

- In 2002, 50% of Oregon 18 to 24 year olds reported binge drinking[168] compared to 28% of 18-24 year olds nationally in 2004.[169]

Note

- Since 2001, there has been an increase of about 4% in the portion of Oregon 11th graders that report binge drinking.[170] Nationally, there has been a decreased trend in binge drinking.[171]

Drinking and Driving

- In 2004, 18% of all 11th graders reported riding, one or more times in the last thirty days, with a driver who had been drinking.[172] Nationally in 2003, 30% of all high school students reported riding, during the last 30 days, with a driver who had been drinking.[173]

- In Oregon, out of all adolescents age 18-24 that reported having one or more drinks in the past 30 days, 3% were at risk[174] for drinking and driving in 2002.[175]

Tobacco Use

- Of Oregon11th graders in a 2004 survey, 17% reporting smoking cigarettes at least one day during the past 30 days.[176] Nationally in 2003, 22% of high school students reporting smoking cigarettes during the last month.[177]

Drug Use and Treatment

- During the 2001-2002 fiscal year, it was estimated that about 7,150 adolescents age 10-17 were in alcohol and drug treatment facilities. The need for alcohol and

drug treatment facilities was estimated to be for about 42,650 young adolescents, far outweighing the current available treatment centers.[178]

INJURY

Motor Vehicle Injury

- In 2003, 25.6 per 100,000 Oregon 15-24 year olds died due to motor vehicle accidents.[179]

Note

- The number of deaths for 15-24 year olds decreased substantially from 1997 and 1998 rates of over 33.0 per 100,000 to the current rate of 20.1 per 100,000. [180]

Sexual Assault and Coercion

- In 2003, 22% of Oregon 11th grade females and 17% of 8th grade females were pressured into sexual activity.[181]

- In 2004, 10% of 11th grade females and 7% of 8th grade females report that they were physically forced to have sex when they did not want to. [182]

- Males in the same grades were less likely to report that they were pressured and forced into sex. In 2003, approximately, 11% of 11th grade males and 11% of 8th grade males reported that they were pressured into sexual activity. In 2004, 3% of 11th grade males and 2% of 8th grade males report having been physically forced to have sex when they did not want to. [183]

Note

- A smaller proportion of teens in Oregon reported being forced to have sex than teens nationally for both boys and girls (2003). [184]
- A large proportion of teens locally and nationally report having been pressured into sexual activity by someone they were dating.[185]

Weapon Carrying

- Most students do not carry weapons on school property. About 1% of all 8th graders and 1% of 11th graders reported bringing a handgun to school at least once in the past 12 months in 2004.[186]

- In 2004, 3% of 11th grade females and 10% of 11th grade males report carrying a weapon other than a gun (such as a knife or club) on school property at least once in the last 30 days. [187]

ORAL HEALTH

Dental Services

- According to a 2003 survey, 7% of Oregon adolescents age 10-17 did not visit a dentist in the past 12 months for any routine preventive dental care, this is slightly higher than the portion nationally (6%).[188]

- In 2004, 25% percent of Oregon 11th graders and 28% of Oregon 8th graders did not visit (did not receive a check-up, exam, teeth-cleaning or other dental work) a dentist or dental hygienist in the last 12 months.[189]

- Thirty-two percent of older adolescents, age 18-24, reported not visiting a dentist in the last 12 months in a 2002 survey.[190]

Dental Insurance

- In 2003, almost 1 in 4 (24%) of adolescents 10-17 lacked dental insurance that helped to pay for routine dental care, 2% more than nationally.[191]

OBESITY, NUTRITION, EXERCISE

Overweight/ Obese

- In Oregon and nationally, 14% of adolescents surveyed in 2003 age 10-17 are considered overweight or having a body mass index of 95 or higher.[192] An additional 12% of Oregon 10-17 year olds and 15% nationally are at risk for becoming overweight (having a body mass index between the 85th and 95th percentile of weight for their height).[193]

- In 2004, 13% of Oregon 11th grades were at risk for becoming overweight (between the 85th and 95th percentile of weight for their height) and an additional 10% were obese.[194] Almost twice as many male 11th graders were obese than females.[195] Nationally in 2003, 2% more high school students[196] were obese (12%) and 2% more are at risk for becoming overweight (15%), than in Oregon.[197]

- For the older adolescents (age 18 to 24), 28% were overweight (BMI = 25-29) and 11% were obese (BMI = 30+) in 2003. [198]

Note

- From 2001 to 2004, the percentage of Oregon 11th graders that were overweight (based on BMI) increased from 7% to 10%.[199]
- There was no change in the proportion of overweight and obese 18 to 24 year olds from 2000 to 2003 (39%). [200]

Exercise

- In 2004, 71% of 11th graders and 81% of 8th graders in Oregon participated in rigorous exercise for 20 minutes 3 or more days a week.[201] For 11th graders, this is up from 60% in the 1997 survey.[202]

5-A-Day

- Twenty-one percent of 11th graders and 30% of 8th graders reported eating 5 or more servings of fruit and vegetables in 2004.[203]

Eating Disorders

- During 2003, over 1 in 5 11th grade girls and almost 1 in 10 boys in the 11th grade were found to be at risk for eating disorders. This proportion was similar for 8th graders.[204]

PREVENTION, RISK REDUCTION AND SCREENING

Well-Child/ Well-Adolescent Visit

- In 2003, 18% of Oregon adolescents age 10-17 did not have a preventive medical care visit or well-child visit in the past 12 months.[205] This is 6% higher than the proportion of 10-17 year olds nationally that did not have a preventative medical care visit or well-child visit in the past 12 months (12%).[206]

Medical Home

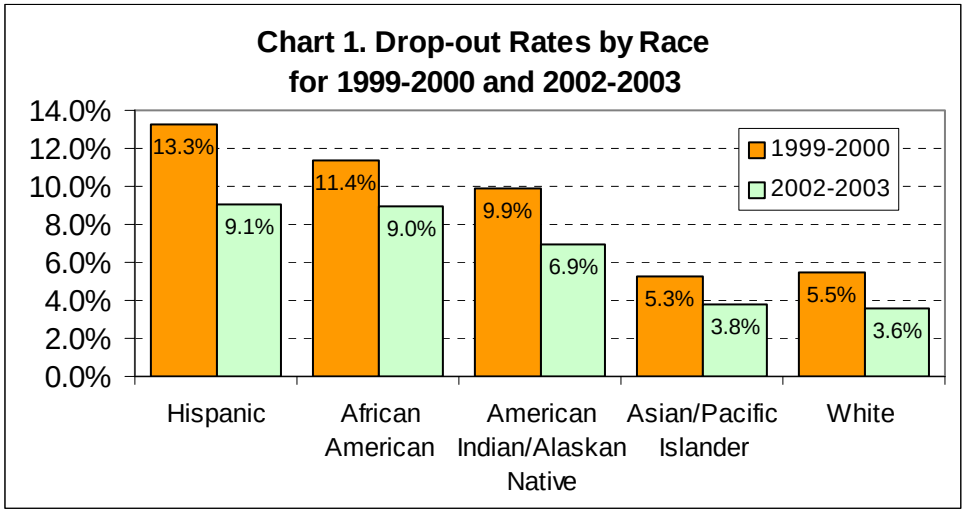
- Out of all Oregon adolescents age 10-17, 16% do not have a person they think of as their personal doctor or nurse, 1% more than nationally (2003).[207]

Truancy

- The dropout rates for Oregon high school students have been decreasing since 1994-95 from 7% to 4% for the 2002-2003 school year. [208]

❖ Disparity

Although there have been decreases for each race and ethnicity, a large difference in rates by race and ethnicity still exists as you can see by the chart below.[209]



REPRODUCTIVE
Pregnancy & Birth

- The pregnancy rate for girls in Oregon age 15 – 17 was 27.6 per 1,000 in 2002, surpassing the 2003 DHS Performance target for 2005 of 36.0 per 1,000. [210]

- The Oregon birth rate for 15-17 year-olds was 18.2 per 1,000 in 2002 compared to the national rate in 2002of 23.2 per 1,000.[211]

Note
- The rates of pregnancy and birth for teenage girls (15-17) in Oregon have decreased. In only 6 years, the birth rate for teens age 15-17 reduced from 26.4 per 1,000 in 1998 to 16.5 per 1,000 in 2003.The pregnancy rate for girls age 15-17 also reduced by almost half over 12 years from 52.2 per 1,000 in 1990 to 26.4 per 1,000 in 2003.[212]

Sexually Transmitted Diseases

- In 2002, chlamydia was the most frequently reported disease in Oregon, accounting for over ½ of all diseases reported.[213] Oregon females age 15-19 and 20 – 24 had a Chlamydia infection rate of 1,649 and 1,735 per 100,000 during 2002.[214] The rates for these age groups is the highest of all women in reproductive age groups.

Note
- The rate of Chlamydia has increased substantially throughout Oregon for all women since 1997. However, it is unclear if this is an actual increase or caused by a lack of diagnosis in previous years.[215]

Condom Use

- In 2004, 34% of all 11th graders that have had sex did not use a condom during the last time they had sexual intercourse.[216] Nationally in 2003, 37% of high school students did not use a condom the last time they had sexual intercourse.[217]

- In 2000, 69% of 18-24 year-olds did not use a condom the last time they had sexual intercourse.[218] This information has not been tracked since 2000.

Note
- There have been no changes in the proportion of 11th graders using a condom the last time they had sexual intercourse since 2001.[219]

CHRONIC DISEASE

Asthma

- In 2003, a smaller portion of Oregon children age 10-17 (12%) than children age 10-17 nationally (15%) have been told by a doctor or health professional that they have asthma.[220]

Type II Diabetes

- About one in 200 children in Oregon and nationally age 10-17 has been diagnosed with Type II Diabetes in their lifetime according to a 2003 survey.[221]

WOMEN (18 years and older)

INSURANCE

Currently Uninsured

- In 2003, an estimated 17% of Oregon women lacked health care insurance. [222] Among other states, the median proportion of women without insurance was 14% (2001).[223]

- Sixteen percent of Oregon women surveyed in 2003 reported that during the past year there was a time when they needed medical attention, but did not visit a doctor because of the cost. [224]

Note

- The portion of women in Oregon without health insurance remained stable at 12% from 1999 through 2001 but rose to 17% in 2002 and 2003. [225]

Government Insurance Coverage

- According to BRFSS, the Oregon Health Plan covered 9% of all women in 2003.[226]

MENTAL/EMOTIONAL HEALTH

Mental Health

- An estimated 12% of Oregon women (3% higher than men) reported that their mental health was "not good" for 15 or more days of the previous month in 2003. [227]

- About 9% of Oregon women over 18 (126,000) are estimated to need mental health treatment.[228] Only an estimated 38% of these women are receiving treatment. [229]

Note

- Since 1999, the portion of Oregon women that reported their mental health was not good for over half of the previous month fluctuated between 10% and 12%. [230]

Suicide

- In 2002, three percent of Oregon women self-reported that they "seriously considered" suicide during the past year. [231]

- Suicide was the 17th leading cause of death for women in Oregon during 2002 causing 85 deaths (4.8 per 100,000 women).[232]

- There were 101.96 per 100,000 hospital discharges related to suicide attempts for Oregon women in 2001, almost twice as high for women as for men (60.14 per 100,000).[233]

Notes

- Over the past few years, between 3% and 4% of Oregon women self-reported seriously considering suicide. [234]
- The rate of hospital discharge for suicide attempts was almost twice as high for women as for men in 2003.[235] Oregon women make more attempts at suicide than Oregon men, but in 2001 there were more deaths to suicide for men (23.13 per 100,000) than for women (6.28 per 100,000).[236].
- Middle-aged women are at increased risk for suicide, compared to both younger and older women. The rate of suicide deaths for females age 35-44 is 7.4 (per 100,000), and age 45-54 is 11.5 compared to 3.4 for females 24-35 and 6.3 for females 55-64 and lower rates for all other Oregon women.[237] Citation should be to Table 6-7f.

SUBSTANCE USE

Alcohol

- According to a 2004 national and state-by-state report card, Making the Grade on Women's Health, Oregon has the 34th worst record for binge drinking with 9% of Oregon women binge drinking during a given month.[238]

- In Oregon in 2002, an estimated 6% of women who reported having at least one drink in the past month drank at least one alcoholic beverage per day on average.[239]

- In 2002, Chronic Alcoholic Liver Disease accounted for 89 deaths of Oregon women and another 41 deaths were alcohol induced by other means.[240]

Note

- There has been no change in the portion of adults (15%-16%) in Oregon and nationwide that report binge drinking since 1990. [241]

Tobacco

- In 2002, about 35% of women in Oregon that had smoked 100 cigarettes in their lifetime smoked on a daily basis.[242]

Note

- There has been little change in the portion of Oregon women that smoke on a daily basis since 1999. [243]

Illicit Drugs

- A 2003 report identifies that approximately 10% of Oregon adults (including men) "abused or depended" on illicit drugs. [244] An additional 29% of Oregon adults reported "some use" of drugs, but do not report abuse or dependency. [245]

- The most commonly used illegal drug is marijuana. [246]

- In 2002, 25 deaths of Oregon women were attributed to drug use (besides alcohol), most of which were to women between the ages of 35 and 54. [247]

Drug and Alcohol Treatment

- A 2003 Mental Health report, estimates 140,000 Oregon women over the age of 18 need treatment for addiction to alcohol or drugs andonly 18,000 or 13% of all adult Oregon women that needed treatment for alcohol or drug addiction are currently enrolled in treatment programs.[248]

INJURY

Motor Vehicle

- Motor vehicle injuries were the leading cause of injury-related deaths among Oregon women between 1999 and 2002. [249]

- Motor vehicle accidents were the third leading cause for unintentional injury related hospitalizations among women during 2001.[250]

- In 2002, seven percent of women self-reported that they did not "always" use a seat belt while in a car.[251]

Note

- There has been little change in the rate of death due to motor vehicle accidents for Oregon women since 1999. [252]

Falls

- Falls are the second leading cause of unintentional injury-related death for Oregon women. [253]

- Falls are the leading cause of non-fatal unintentional injuries requiring hospitalization among adult women (18,190 between 1999-2001).[254] Death due to falls is much less common for women under the age of 65.[255]

Abuse

- In 2002, an estimated 3% of Oregon women reported being subjected to physical violence in the past year.[256]

- In Oregon one of our 2005 DHS Performance Measure targets was to decrease domestic violence to 2%. Although BRFSS data indicates that we have met this goal with 1% of all women reporting domestic violence, limitations to this source suggest that this is an underestimate. [257]

- An estimated 10% of Oregon women age 20-55 experienced physical or sexual abuse from their intimate partner in the last 5 years. [258] Annually, intimate violence is estimated to occur for about 3% of Oregon women.[259]

- Approximately 11,000 Oregon women that were physically abused and 7,500 women that were sexually abused had serious injuries. [260] Of women, only 2 in 5 victims of physically abuse and 1 in 5 victims of sexual abuse were treated for injuries. [261]

Domestic Violence Shelters

- In 2003, 2,775 adults were sheltered in emergency shelters, motels or safe homes in Oregon due to physical or sexual abuse. [262]

- Of the Oregon women sheltered, 52% had one or more child with them. [263]

- In addition to the almost 3,000 adults that were sheltered, there were another 12,882 requests for shelter that could not be met. [264]

- Almost 80% (78%) of the sheltered Oregon adults were between the ages of 21 and 44.[265]

Note

- In Oregon, the need for Domestic violence shelters far exceeds the supply. For every person who received shelter there are 4 whose requests could not be met. [266]

ORAL HEALTH

- In 2002, an estimated 17% of adult Oregon women self-reported they had not been to a dentist for teeth cleaning in more than 2 years.[267] An estimated 70% of Oregon women had visited a dentist in the past year (2% less than nationally) according to a 2004 source. [268]

- For every adult (19+) without medical insurance in the U.S., the CDC estimates that there are 3 without dental insurance.[269]

Note

- The portion of women that have not had their teeth cleaned in over 2 years has fluctuated between 17% and 22% between 1999 and 2002. [270]

OBESITY, NUTRITION, AND EXERCISE

Weight Issues

- In Oregon, as well as nationally, about 50% of all women were overweight (BMI = 25-29.9, 29%) or obese (BMI 30+, 22%) in 2003.[271] Oregon had the 22nd lowest rate of obesity compared to the other states. [272]

Note

- There has been little change in the portion of Oregon women estimated to be overweight or obese since 2001.[273]

Nutrition

- In 2003, about 1/3rd (30%) of Oregon women are estimated to eat 5 or more fruits and vegetables a day. [274] Nationally only 28% of women eat the recommended daily allowance of fruits and vegetables daily. [275] Oregon ranks 11th at meeting this goal among all states. [276]

Note

- Since 2001, the percent of Oregon women eating the recommended serving of fruits and vegetables has remained between 29% and 32%.[277]

Exercise

- According to a 2004, state-by-state report, Oregon ranks 4th among all states at having the greatest portion of women that do some sort of physical activity during their leisure time.[278] However, 20% of Oregon women in 2003 did not do any physical activity during their leisure time (compared to 27% nationally).[279]

- In 2003, an estimated 56% of Oregon women reported not doing vigorous physical activity during their leisure time. [280]

Note

- There has been no change in the data regarding how much physical and vigorous activity Oregon women report doing during their leisure time from 1999 to 2003.[281]

PREVENTIVE AND SCREENING

Routine Check-ups

- In 2002, it was estimated that 13% of Oregon women have not had a routine check-up in more than 2 years. [282]

Mammograms and Pap Smears

- Fourteen percent of adult Oregon women reported not having had a pap smear in the past 3 years, slightly more than nationally (13%), in 2002. [283]

- According to a 2004 report, 76% of women between 40 and 64 Oregon and nationally report having had a mammogram in the past 2 years. [284]

Medical Home

- During 2003, 17% of women reported not having one person they think of as their personal doctor or health care professional. [285]

Immunizations

- Flu shots are recommended for high-risk adult populations including those over 65. In 2003, about 71% of Oregon adults over age 65 received a flu shot.[286] Thirty-four percent of Oregonians age 18-64 with Asthma reported receiving a flu vaccine in 2003, the same as nationally. More Oregon adults (18 – 64 years) with diabetes reported receiving the flu vaccine than nationally (55% and 49%, respectively) in 2003.[287]

- Oregon DHS Immunization Program has a five-year objective to increase the coverage levels for pneumococcal immunization among adults age 65 and over and ages 18-64 with medical risk factors. The objective is to increase the coverage in these populations by five percent to 76% and 44% by 2006, respectively. Seventy-two percent of Oregon adults 65 and over reported having received at least one pneumonia shot in their lifetime in 2003.[288] In 2003, the proportion of adult Oregonians (18 – 64 years) with diabetes that had received the pneumococcal immunization was 48%, 9% higher than the U.S. median for 18-64 year olds with diabetes. [289]

CHRONIC DISEASE AND CANCER

Cancer

- In 2003, cancer was the leading cause of death for Oregon women (197.7 per 100,000).[290] In 2002, Bronchial and lung cancer accounted for 56.4 deaths per 100,000 women in Oregon[291] Breast cancer accounted for approximately one half as many deaths to Oregon women (28.3 per 100,000) as bronchial and lung cancer in 2002.[292]

- Breast cancer is much more common among women than lung cancer. However, because of the high mortality rate of lung cancer, nearly twice as many women die from lung cancer as from breast cancer.

Cardiovascular Risk Factors and Disease

- Heart disease was the leading cause of death for Oregon women from at least 1997 through 2001. In 2002 and 2003, heart disease slipped narrowly to the second leading cause of death (187.9 per 100,000).[293]

- In 2003, almost ¼ of all Oregon women are estimated to have high blood pressure. [294] Of those with high blood pressure, 77% report taking medication for their blood pressure. [295]

- Of the 73% of Oregon women who reported having had their cholesterol checked in 2003, 33% were diagnosed with high cholesterol. [296]

- Approximately 3% of women in Oregon self-reported having had a heart attack or myocardial infarction in 2003. [297]

- In 2003, 3% of Oregon women reported being diagnosed with angina or coronary heart disease. [298]

- In 2003, 3% of Oregon women reported being diagnosed with a stroke in their lifetime. [299]

Arthritis

- An estimated 31% of Oregon women have been told by a health professional that they have some form of arthritis.[300]

- Oregon has one of the highest rates of arthritis for women in the nation, ranked 42nd.[301]

Note

- The percentage of women with arthritis increases with age and is much more common for women over age 55.[302]

- There was an increase from 27% in 2000 to 31% in 2003 of Oregon women who reported that a healthcare professional has told them they have some form of arthritis.[303]

Asthma

- An estimated 16% of Oregon women (compared with 11% of Oregon men) reported having been told by a doctor or other health professional that they have asthma in 2002.[304]

Note

- There has been little change in the percent of women that are estimated to be diagnosed with asthma (1999, 14% to 2002, 16%).[305]

Diabetes

- In 2002, an estimated 6% of Oregon women have been diagnosed with diabetes[306], compared to 7% nationally.[307]

COMMUNICABLE DISEASE

HIV and AIDS

- In 2001, an estimated 55% of Oregon women between 18 and 65 had never been tested for HIV. [308]

- Oregon ranks 11th among all states for having the lowest rate of AIDS for women.[309]

- The annual rate of death related to HIV or AIDS for Oregon women is very low, (0.5 per 100,000).[310] Among Oregon men, deaths with a cause of AIDS were ranked 17th in 2003 among all causes (4.8 deaths per 100,000). [311]

Note

- There has been little change in the portion of adult women that have been tested for HIV over the past 4 years. [312] Adult women between the ages of 25 and 34 were more likely to have been tested for HIV than women under 24 or over 35.[313]

Chlamydia

- A 2004 report card indicated that in Oregon, 4% of women have Chlamydia (compared with 6% nationally).[314]

PREGNANT WOMEN

INSURANCE

- In Oregon, during 2003, the majority of births were paid for by private insurance (58%), however 37% of all births were paid for by the Oregon Health Plan and 3% self-paid.[315]

Note

- The portion of births covered by private insurance has decreased from 60% in 2001 to 58% in 2003.[316] A steady increase occurred in the percentage of births paid for by government insurance; 32% in 1999 to 37% in 2003.[317] There was also an increase in the uninsured population during this time period.

- Mothers whose deliveries were paid for by the Oregon Health Plan had higher rates of inadequate prenatal care according to the Kotelchuck Index[318] than mothers using insurance other than Medicaid; 24% and 19% respectively.[319]

MENTAL/EMOTIONAL HEALTH

Perinatal and Postpartum Depression

- One of the Healthy People 2010 objectives is to reduce postpartum depression. Recent analysis of various sources (including both self-reported and clinically diagnosed) of postpartum depression data estimated the prevalence of postpartum depression around 13% of women nationally and that about 12% of women suffer from depression during the 2nd and 3rd trimesters of pregnancy.[320]

- It is estimated that health care providers identify only 20-30% of perinatal mood disorders which includes depression during pregnancy and up to 1 year postpartum.[321]

- Women who are suffering with perinatal depression are more likely to face substance abuse issues, marriage problems, employment problems and suicidal concerns and they are less likely to promote the child's cognitive and emotional development. [322]

SUBSTANCE ABUSE

Tobacco

According to the CDC, " Pregnant women who smoke are more likely to have babies who have an increased risk of death from sudden infant death syndrome and respiratory distress. They are also more likely to have low birth-weight babies; low birth weight is linked to many infant health disorders."[323]

- In 2003, 12% of Oregonians who gave birth reported using tobacco while pregnant.[324] This finding meets the 2005 DHS Performance target of 12%.

Note
- Between 1999 and 2003 the percent of Oregon women using tobacco while pregnant decreased from 15% to 12%.[325]

- Women under 25 are twice as likely to smoke during pregnancy as those 25 or older, 20% in the younger group compared to 6% in the older group.[326]

Alcohol

- In 2001, 52% of women in Oregon that gave birth reported consuming alcohol in the 3 months before pregnancy.[327]

- Approximately 2% of the female population of age 15- 50) were in treatment for alcohol and other drugs.[328]

- According to a 2002 Mental Health report, an estimated 18% of the total female population in Oregon is in need of, but not able to receive treatment for, addiction and substance abuse issues.[329]

Note
- The portion of women self-reporting that they abstained from alcohol during pregnancy has steadily increased from 95% in 1990 to 98% in 2003.[330]

- Sixteen infants in Oregon in 2003 were born with fetal alcohol syndrome.[331]

- In 2002 infants with mothers that used alcohol during pregnancy had twice the rate of perinatal period[332] deaths (11.9 per 1,000 live births) than infants of mothers that did not use alcohol during pregnancy (5.3 per 1,000).[333]

Illicit Drugs

- Drug use is commonly underreported. In 2003, almost 99% of Oregon mothers self-reported not using illicit drugs during pregnancy.[334]

Note
- There has been little change in the portion of pregnant women who self-report using illicit drugs while pregnant since 1999.[335]

INJURY

Abuse

- Approximately 2% of Oregon pregnant women reported being physically hurt[336] by their husband or partner during 2001.[337]

- Over 4% reported being physically hurt[338] by their husband or partner in the 12 months prior to becoming pregnant.[339]

- An additional 1% of PRAMS (Pregnancy Risk Assessment Monitoring System) respondents said that someone besides their partner had physically hurt them during their most recent pregnancy.[340]

- In other states surveyed by PRAMS, the percentage of pregnant women being abused ranged from 3% to 7% (1999).[341]

PREVENTIVE AND SCREENING

Prenatal Care

- In 2002, Eighty-two percent of new Oregon mothers received prenatal care beginning in the first trimester. [342] The Oregon Benchmark target is that 85% of new Oregon mothers receive prenatal care beginning in the first trimester.[343]

- In 2003, 22% of women who gave birth in Oregon did not have 80% or more of the recommended number of prenatal visits.[344]

- In 2002, 89% of Oregon's low-income pregnant women that were on Medicaid received prenatal care in the first 4 months of pregnancy, exceeding the DHS Performance target for 2005 of 87.5%.[345]

Note

- The percentage of Oregon baby's mothers that received prenatal care beginning in the first trimester has increased steadily since 1990 when it was at 76%.[346]

- Among low-income women receiving Medicaid in Oregon, prenatal care utilization in the first 4 months of has increased substantially since 1999 (1999, 84% to 2002, 90%).[347]

- In 2003, about 6% of Oregon women receive "inadequate" prenatal care; defined as having 5 or less prenatal visits or care that began in the 3rd trimester.[348]

❖ Disparity

The proportion of births with "inadequate" prenatal visits was higher for minorities, specifically for American Indians (13%) and Hispanics (9%) than non-Hispanic Whites (5%).[349] Eight percent of Non-Hispanic African Americans also received "inadequate care."[350]

❖ Disparity

The proportion of pregnant women with "inadequate care" was higher for mothers under the age 24[351], and women with less than a high school education.[352]

Folic Acid Use

- In Oregon, 37% of Oregon women reported taking a multi-vitamin with folic acid four or more days per week prior to becoming pregnant, not yet meeting the Oregon target of 45% by 2005.[353]

Immunizations

- The CDC recommends that all people who are at high risk from complications of influenza receive flu shots. Pregnant women are included in this high-risk category. An estimated 43% of adults age 18-64 at high-risk nationally received flu shots in 2003, this group includes pregnant women.[354]

Teen Pregnancy

- The pregnancy rate for girls in Oregon age 15 – 17 was 27.6 per 1,000 in 2002, surpassing the 2003 DHS Performance target for 2005 of 36.0 per 1,000. [355]

- The Oregon birth rate for 15-17 year-olds was 18.2 per 1,000 in 2002 compared to the national rate in 2002of 23.2 per 1,000.[356]

Note

- The rates of pregnancy and birth for teenage girls (15-17) in Oregon have decreased. In only 6 years, the birth rate for teens age 15-17 reduced from 26.4 per 1,000 in 1998 to 16.5 per 1,000 in 2003.The pregnancy rate for girls age 15-17 also reduced by almost half over 12 years from 52.2 per 1,000 in 1990 to 26.4 per 1,000 in 2003.[357]

HIV Testing

- The CDC recommends that all pregnant women receive an HIV test in order to reduce the number of HIV transmissions to infants. In 2002, an estimated 62% of pregnant women in Oregon received an HIV test, up from 57% in 2001.[358]

Note

- From 1998 to 2001, there was little fluctuation in the portion of pregnant Oregon women that received an HIV test. [359]

UNINTENDED PREGNANCY

- An estimated 53% of all Oregon pregnancies were unintended (new mothers reporting they would rather have been pregnant later or not at all) or terminated in 2002; this does not meet the 2005 DHS Performance target of 48.5%**.**[360]

- In Oregon, an estimated 39% of births were unintended (new mothers reporting they would rather have been pregnant later or not at all) in 2002.[361]

- In 2003, 21% of all pregnancies ended in abortion.[362]

Note
- The portion of Oregon pregnancies that were unintended or terminated improved very little over the past four years (54%).[363]

- A major issue related to unintended pregnancy is the availability of emergency contraception (E.C.). In Oregon 25% of new mothers reported not having heard of E.C. in 2001.[364]

Note
- There has been a slight increase in the percentage of women aware of emergency contraception since 1999, 5% more new mothers were aware of its existence. [365]

ORAL HEALTH

- Pregnancy is a time when women's teeth and gums are particularly sensitive to decay. In 2001, about 56% of new Oregon mothers had not had their teeth cleaned in the past year.[366]

BIRTH OUTCOME

Low Birth Weight

- In 2003, 6.1 per 1,000 live births in Oregon were low birth weight (<2500 grams).[367] Nationally, 7.8 per 1,000 live births were low birth weight in 2002.[368]

Note
- The rate of live births (including multiple births) in Oregon that were low birth weight was about 5.4 per 1,000 live births from 1996 through 1999, but have since increased steadily to 6.1 per 1,000 live births.[369]

❖ **Disparity**

In 2002, the national rate of low birth weight infants for African Americans is twice as high as for whites, 13.3 per 1,000 and 6.8 per 1,000 respectively.[370]

Birth Defects and Infant Mortality

- Almost half of all infant deaths (118 of 260) were caused by conditions originating in the perinatal period.[371]

- Among deaths that occurred during the perinatal period, approximately 1/3rd (34) were connected to maternal factors and another 1/3rd (36) were caused by gestation and fetal growth.[372] Fifteen fetal deaths were caused by disorders related to short gestation and low birth weight.[373]

- Sixteen infants were born with Fetal Alcohol Syndrome in Oregon during 2003.[374]

- Infants with mothers that use alcohol during pregnancy have twice the rate of death during the perinatal period[375] compared with infants whose mothers did not use alcohol (11.9 per 1,000 and 5.3 per 1,000, respectively).[376]

- The infant mortality rate in Oregon is 5.8 deaths per 1,000 live births.[377] Our Oregon Benchmark target for infant mortality rate in 2005 is 5.1 deaths per 1,000 and 4.5 by 2010.[378] In 2002, 7.0 infant deaths were reported per 1,000 live births nationally.[379]

Note
- The infant mortality rate decreased substantially from 1990 (8.3 deaths per 1,000 live births) to 1996 (5.6 deaths per 1,000 live births). From 1997 through 2003 the infant mortality rate has fluctuated between 5.4 and 5.8 deaths per 1,000 live births.

- Congenital Malformations, low birth weight and sudden infant death syndrome (SIDS) account for 44% of all infant deaths in the United States.[380]

- In Oregon, congenital malformations accounted for almost ¼ of all infant deaths.[381] In Oregon, SIDS accounted for 31 deaths (0.7 deaths per 1,000 live births) in 2002.[382] Another 9 deaths were caused by accidental suffocation and strangulation in bed.[383]

Note
- Following a national trend, the proportion of Oregon infant deaths attributed to SIDS reduced 20% in 2000 to 12% in 2001 and 2002.[384]

❖ **Disparity**

In Oregon, the infant mortality rate was twice as high for African Americans (9.9 per 1,000) as for whites (5.1 per 1,000).[385] Nationally, the rate of infant mortality for African Americans is even higher, 13.6 per 1,000 compared to 5.7 per 1,000 whites nationally.[386]

❖ **Disparity**

Infant mortality rates are higher for those mothers, regardless of race/ethnicity, who: did not receive prenatal care, are teenagers, had less than a high school education, were unmarried, or who smoked during pregnancy.[387]

BREASTFEEDING

Breastfeeding

- Almost 90% of Oregon mothers are breastfeeding their infants at hospital discharge, compared to only 70% nationally.[388]

- At six months of age, an estimated 50% of Oregon infants are being breastfed, compared to only 33% nationally.[389]

- According to the 2002 PRAMS data, 70% of women were still breastfeeding their infants at 10 weeks of age.[390]

- At 6 months of age, 43% of Oregon infants enrolled in the Women, Infants and Children Program (WIC) were still being breastfeed.[391] Only 22% of infants enrolled in WIC nationally are being breastfed at six months of age.[392]

Note

- Rates of breastfeeding at hospital discharge have steadily risen since 1992 in Oregon.[393] Breastfeeding rates at 6 months of age rose from 34% in 1992, to 50% in 2002. [394]

PATERNITY AND TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES)

- Establishing paternity for the babies of unwed mothers increases the amount of TANF funds received by the State of Oregon. Paternity is established by both parents signing a voluntary affidavit at the time of their child's birth. Paternities are processed by the Center for Health Statistics on an ongoing basis.[395]

- Receipt of the statewide paternity affidavit declined from 75% in fiscal year 2002-2003 to 69% in fiscal year 2003-2004. [396]

- Between fiscal year 2002-2003 and 2003-2004, the number of births to unwed mothers increased by 349 births or 2.4%.[397]

- Review of paternities established at the hospitals between fiscal year 2002-2003 and 2003-2004 shows that 27 of 56 hospitals (48%) had a decline in the percentage of completed voluntary acknowledgment of paternity forms for unwed mothers.[398]

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Oregon Local Health Authority Brief Adolescent Health Systems Capacity Assessment

In order to understand the capacity for county health departments to serve the adolescent population, the Oregon Adolescent Health Section (AHS) adapted a state level capacity assessment tool for use in measuring county adolescent health capacity. The state level tool was developed by the Association of Maternal and Child Health Programs and the National Network of State Adolescent Health Coordinators (NNSAHC) with support from the Annie Casey Foundation in 2004.

The modified tool developed by AHS was distributed to all 35 health departments in the state. Participants were asked to complete the tool, reporting a consensus score using a group process that involved a minimum set of key informants and decision makers. The tool consisted of a one page double-sided form utilizing 15 questions to measure 6 key capacity areas. The purpose of this numerically scored tool was to measure local capacity to improve adolescent health.

Results

As of this writing 27 of the 35 county health departments have returned a completed tool (77% response rate). The average percent score on this tool is 57%. Overall, mean scores were highest for the *Elements of Technical Assistance* and the *Elements of Effective Partnerships* capacity areas and lowest for the *Elements of Effective Planning* and *Formal Commitment to Adolescent Health* capacity areas (Chart 1).

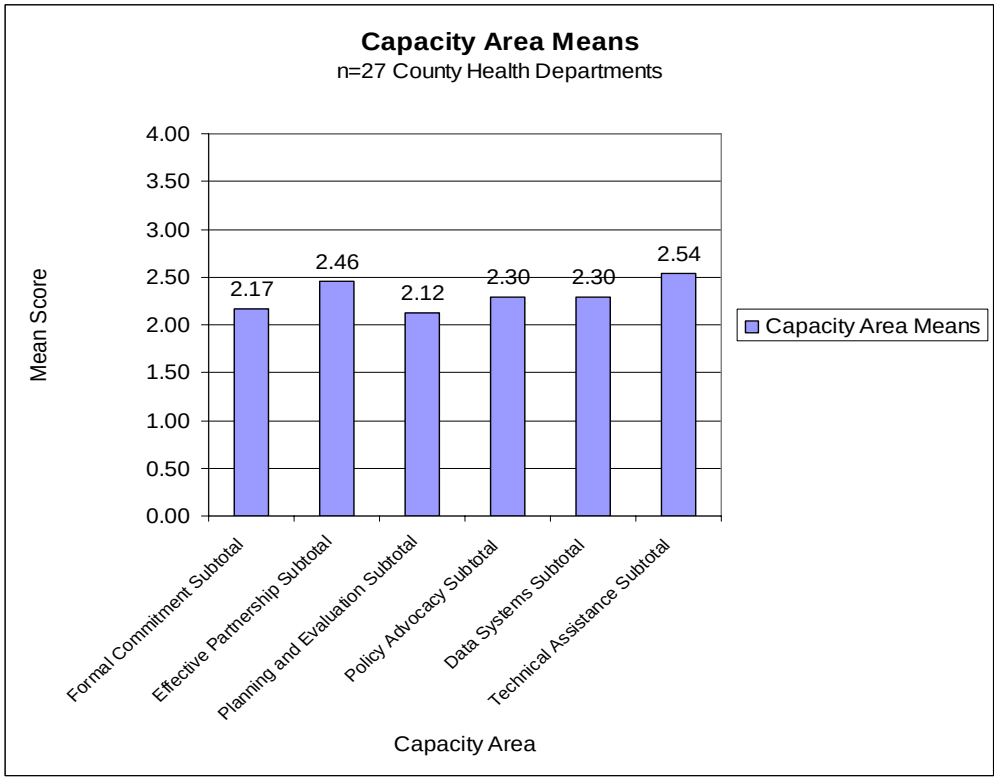

Chart 1
Capacity Area Means for Reporting Counties

The five most populous reporting counties had higher scores than the five least populous reporting categories for all capacity areas except the *Planning and Evaluation* Area for which the two groups received an identical score (Chart 2). The five most populous counties received slightly lower mean scores than the

mean scores for the full sample of counties in the capacity areas of *Policy Advocacy* and *Technical Assistance.*

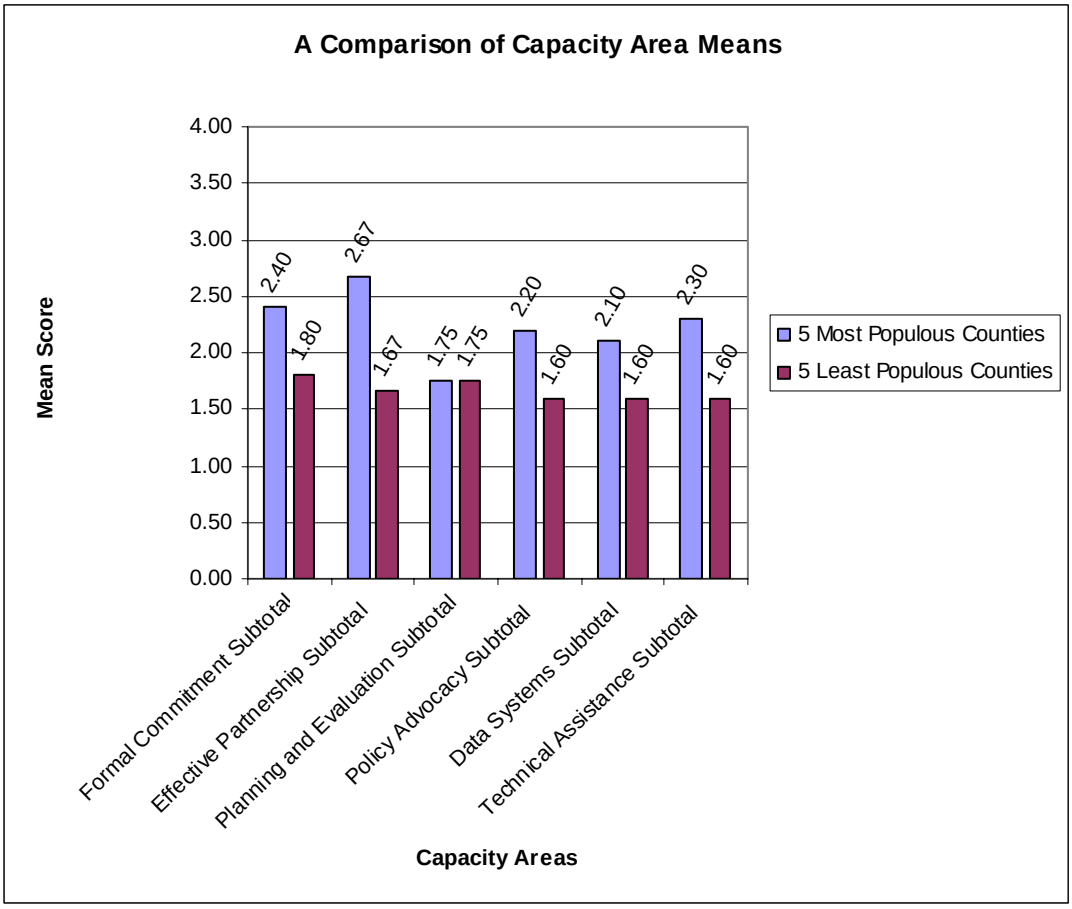

Chart 2
The capacity area mean scores of the top five most populous participating county health departments compared with the corresponding scores for the five least populous participating county health departments.

Discussion

The ability of Oregon counties to respond to adolescents as a unique population varies. Counties tended to score better in capacity areas that depended primarily on relationship building such as *Effective Partnerships* and *Technical Assistance* rather than capacity areas that are grounded on planning and data gathering.

Participating county health departments received their highest scores in the *Technical Assistance* and *Effective Partnership* capacity areas. Almost half (48%) of reporting counties rated themselves as good or excellent on the *Technical Assistance* capacity area. One third (33%) of counties rated themselves as good or excellent on the *Effective Partnership* capacity area

The weakest capacity area for counties was *Planning and Evaluation*. Less than one fifth (18.5%) of Oregon counties rated themselves as good or excellent on this capacity area. The mean for this capacity area was identical for the five most populous and the five least populous counties. This is the only capacity area in which the five most populous counties did not have a higher score than the least populous counties.

Interestingly, the lowest mean score and highest mean scores on any single question within the tool were received by questions within the same capacity area-- *Elements of Effective Partnership* (Figure 1). Question

four which asks about relationships with youth and families as well as youth development activities received the lowest score. This is an important finding as youth development (i.e. Positive Youth Development) is a rapidly developing framework for working with youth that has received considerable national attention and recognition during the last decade. Within the youth development framework, adolescents are empowered to both contribute to their community and participate in community decision making[1]. In contrast, public health has traditionally utilized a more risk-protective factor orientation paradigm. It appears, while local public health departments demonstrate overall effective community partnering skills they are less centered on engaging youth and their families directly.

Elements of Effective Partnerships for Adolescent Health
3) Does your local health department have *Informal and Formal Partnership Structures?* Some examples include evaluation, accountability, reciprocal relationships, coordination of resources, and/or collaboration.
4) Does your local health department have *Family and Youth Partnerships and Youth Development* activities? Some examples include youth and family participation/input, appropriate representation, youth and family empowerment, and/or youth/family/adult communication.
5) Does your local health department have *Youth Serving Partnerships?* Some examples include appropriate representation, health and human service partnerships, partnerships with state and community organizations, and initiatives, partnerships with education, and/or partnerships to reach out-of-school youth.

Figure 1

Another notable finding from this process has confirmed that Oregon counties have a limited *formal commitment* to adolescent health. The formal commitment to adolescent health was operationalized in the brief capacity assessment tool by two questions. One of these questions asked counties had an adolescent health *focal point*. Some examples include a dedicated adolescent health program, or a written statement such as a mission statement or strategic plan which included adolescent health priorities. The second question in the formal commitment capacity area asked if the local health department had dedicated adolescent health staff. Less than half (44%) of the reporting counties rated themselves as good or excellent on this element. In Oregon counties, the needs of the adolescent population are often addressed by staff who serve multiple programs or in some cases the entire Maternal and Child Health population. These finding underscore the limited resources with which many Oregon counties must serve their populations and may reflect that historically Maternal and Child Health programs have been built on programs designed for infants and their mothers.

Several positive and unexpected outcomes occurred as a result of this process. Numerous counties remarked that the brief group process used to fill out the tool was one of the first times they had gathered to review and consider their adolescent population as a whole within their public health system. Typically they reported a pattern of discussing adolescents just within a specific program (e.g. family planning). The process that was used served to promote dialogue and enhance connections. One participating county, as direct result of engaging the tool, began an adolescent health strategic planning process. Another county increased their formal commitment to this population by re-allocating staff time to create a dedicated position for their adolescent health programming.

[1] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. Improving the Health of Adolescents and Young Adults: A Guide for States and Communities. Atlanta, GA: 2004.

Assessment of the Office of Family Health's Work in the Early Childhood System
Overview for OFH managers 8/31/04

What is the purpose of doing an assessment of the OFH's work in the early Childhood system?

- To develop a shared understanding of OFH's role and work in the Early Childhood System; and to develop strategies for strengthening OFH's contribution to Oregon's system of early Childhood Services and supports.

Why do this work at this time?

Take advantage of the opportunity provided by the larger ECHS planning initiative to:

- Define for ourselves how the OFH best contributes to the Early Childhood System in Oregon;
- Identify opportunities to strengthen OFH's partnerships, and improve Oregon's systems of services and supports for young children.
- Align ourselves internally to strengthen the leadership role of OFH in promoting the health of children and families through the Early Childhood System.

How we will approach the work

- Use the appreciative inquiry process to:
  - identify the core strengths, opportunities and challenges involved in the OFH's work in the early childhood system; and
  - Develop a direction and plans for OFH's work that build on the opportunities and strengths of our office, and are grounded in a vision of the possible.

- Involve OFH staff and management in all phases - the discovery of what is now, and the development of what might be, and the design of what will be. Use the wisdom, strengths and enthusiasms of OFH staff and management to guide the process.

Why use Appreciative Inquiry for this process?

- Appreciative inquiry is a method that holds great potential for motivating positive change. It is increasingly evident that we get better results by building on what works than by seeking out and solving problems.

- Appreciative Inquiry provides a positive approach to weathering a time of organizational change, and focusing on how our work can be most effective and satisfying.

- This is an opportunity to build upon the base work in appreciative inquiry that the staff and management have already done with Rob Voyle

What will be the outcome of this process?

- A shared understanding of what we are doing well and how we are contributing to the Early Childhood System now, as well as how we are addressing challenges to our work in this system.

- A picture of what could be – how the OFH could: strengthen its leadership, program development and implementation roles; and amplify the impact of its work in the Early Childhood System

- Recommended strategies and changes that could be adopted within OFH to support and strengthen the office's work in the Early Childhood System.

What we need from OFH managers

- Set-aside 1 – 1 ½ hours of a staff meeting sometime between mid-September and the end of October for the OFH appreciative inquiry project discovery process. Let Nurit Fischler know when the time is and she will arrange to attend the meeting and facilitate the session.

- Support your staff's participation in topic-specific sessions to be held in late October through Early December. (Topics will be: access to medical home, social-emotional health, early care and education, parenting education, and family support)

- As a group - schedule one all-Center staff meeting in early January to bring together the threads from the various meetings and complete the work.

- Lend your support and enthusiasm to the process.

Assessment of the Office of Family Health's work with the Early Childhood System

OFH All-Staff meeting 1/26/05

Meeting Notes

OVERVIEW

Overarching Topic of Inquiry

How can the Office of Family Health best promote the health of Oregon's Young Children and families through the Early Childhood System?

Dreaming to design session…

How do we use what we know about our strengths/ contributions, and our dreams for OFH's work with the Early Childhood System to craft a plan for action?

FIRST BREAKOUT – Prioritization of OFH activities related to various sectors of the early childhood system

What 3-5 things can OFH do to strengthen our work with the ___ sector of the early childhood system and move towards our envisioned ideal?

Cross-Cutting Work

1. Increase family and youth involvement in OFH policy and program design, development , implementation and evaluation
2. Strengthen comprehensive data collection and analysis, focusing on:
    a. Integration (e.g. Family Net)
    b. Data sharing
    c. Filling data gaps (eg. Elementary age children)
3. Promote coordination, and support partners through a focus on the prevention and health promotion end of the service continuum
4. Promote universal developmental screening
5. Improve communication and relationships within DHS and Between DHS and other private and public early childhood partners

Childcare and Early Education Systems

1. Develop consultation capacity (OFH) to childcare providers and other partners; include a marketing plan.
2. Use the coordinated school health model as a base for expanded partnerships.
3. Coordinate the regulatory and educational functions of public health with the Childcare Division.

Mental Health and Social/Emotional Development Systems

1. Assure that the public health workforce and other early childhood service providers are educated about mental health and social/emotional development, and trained to refer to mental health services.
2. Integrate prevention and screening/early identification of risk conditions for mental health into public health settings

3. Work with partners to assure that children and parents have access to prevention, screening, diagnosis and treatment for mental health/social emotional development issues.
4. Advocate for increased capacity of the child and family mental health service system to address both prevention and treatment.

Medical and Health Care Systems

1. Promote increased use of information technology for Medical and Health Care Systems improvement: eg, electronic medical record, e-exchange of data, Child health profile for use by providers
    a. Purpose: multidisciplinary patient care, QI, and PH Surveillance

2. Increase our facilitation, liaison and collaboration with public/private stakeholders
    a. Tools: web integration

3. Work to increase access to care and reduce health disparities through:
    a. Increased focus on our responsibility to ensure that issues of access and health disparities rise to the top/stay in the forefront for decision-makers at all levels (including the voting public & legislators), via our role in:
        i. Collecting data on these issues
        ii. Analyzing the data
        iii. Disseminating the data to all stakeholders and decision-makers

        Our ability/capacity to collect, analyze and disseminate data is of critical importance, and needs continual assessment
    b. Approach I&R as an access to care issue
        i. e.g., SafeNet
    c. Create Linkages between existing health systems
        i. Link formal/informal systems of care
        ii. Advocacy for partnering solutions

Parent Education and Social Services/Family Support Systems

1. Commit to actively work with Child Welfare:
    a. Go to them (multidisciplinary groups)
    b. Make our information more accessible to them
    c. Invite partners to our presentations/trainings
    d. Use technology to help us do the work
2. Work with partners on comprehensive, integrated approach to home visiting – starting before birth.
3. Build on our current partnerships with DHS to synchronize policies and programs – using a client-centered philosophy.
4. Provide education and resources on child health and development to social service workers and foster homes
5. Increase local capacity to partner with social services and parent education through TA and needs assessment.

Second Breakout Session – How to get there….

Top suggestions for what OFH could do internally/structurally to move towards our ideal work with the Early Childhood System

Top Ten Overall

Topic	Votes	Category
Communicate clear, achievable expectations and support efforts to meet them; Promote boundary-setting; focus on what we do well	23	Leadership
Create a unit within OFH that works specifically with community partners/outreach - this could dedicate staff to work with providers, families, community and employers; create a position to focus on outside collaborative activities	21	Organizational Infrastructure
Support employees to promote cross-office, cross-disciplinary work and partnership building- as a critical job priority, not as an add-on to already full jobs	17	Staff support
Manageable workloads so that staff can concentrate on doing a thorough job, not be stretched over too many projects	16	Staff support
Form a dedicated group to focus on program integration – creative approaches to cross-section collaboration and collaboration with outside partners:	16	Organizational Infrastructure
Keep the focus on identified priorities and commitment to the vision we develop	11	Leadership
Add more definition to high level plans and vision (strategic planning);	10	Leadership
Promote program and work efficiency	10	Organizational Infrastructure
Dedicate more resources to transforming our data into information- use it for policy/program development	10	Funding
Salary and benefits	9	Staff support

SUMMARY - CAPACITY ASSESSMENTS

The summary below represents needs according to the 10 Essential Services, the early childhood system integration in OFH, and the local adolescent health capacity. The information on assets and strengths are well-documented in the assessment findings and will be included in future strategic planning and evaluation. The interpretation of needs by Essential Services and by Title V Pyramid level is subjective rather than scientific. However, assessment according to these frameworks provides an method to organize information to plan for action. For purposes of this summary, the needs listed below may be interpreted as:

- Local needs - *Direct and Enabling Services*
- State needs - *Population-Based and Infrastructure Services*

The Summary results are sorted according to the system that was assessed:

- *Public health system* – state and local whole public health systems
- *MCH system* – local MCH systems, Office of Family Health state-level system
- *Office-level early childhood systems* – Office of Family Health programs
- *Adolescent health capacity* – county health departments

CAPACITY NEEDS BY ESSENTIAL SERVICES

#1: Assess and monitor health status

Public Health System:

- Local: Access to and utilization of current technology
- Local: Population-based community health profile
- State: Organize data in a public health profile
- State: Compile and provide data to organizations for surveillance
- State: Develop uniform set of health indicators
- State: Provide standard set of health-related data to partners
- State: Share system-wide resources to monitor health status

MCH Systems:

- Local and State Office: Assessment scores were greater than 50%, or "substantially or fully met"

OFH Early Childhood System:

- Strengthen comprehensive data collection and analysis, focusing on: integration (e.g. FamilyNet), data sharing, filling data gaps (eg. elementary age children)
- Dedicate more resources to transforming data into information to use for policy/program development

#2: Investigate health problems & hazards

Public Health System:

- Local: Assessment scores were greater than 50%, or "substantially or fully met"
- State: Provide screening tests in response to exposures to health hazards

MCH System – not assessed
OFH Early Childhood System – no comments

 # 3 Inform, educate and empower the public

Public Health System:

- Local: Health education and health promotion activities
- State: Deliver culturally and linguistically appropriate health education and health promotion materials and activities
- State: Involve the population served in the design and implementation of reviews
- State: Use resources for effective health communication, and health education and promotion interventions
-

MCH System:

- Local: Utilize a system for identifying existing and emerging health education and health information needs appropriate for target audiences
- State: covered in public health system

OFH Early Childhood System:

- Develop consultation capacity in OFH to support childcare providers and other providers and partners, including a marketing plan

 # 4 Mobilize partnerships

Public Health System:

- Local: Constituency development
- Local: Community partnerships
- State: Build constituencies to address health issues
- State: Brief state and local policy leaders using established procedures and timelines
- State: Provide consultation and training to local health systems and state partners to build partnerships for community health improvement
- State: Evaluate and review constituency-building and partnership facilitation activities, including participation and commitment of its partners
- State: Share system-wide resources to develop constituencies and mobilize partnerships

MCH System:

- Local: Provide information to targeted community audiences on local MCH status, trends and needs
- Local: Convene, stimulate, and/or provide resources (e.g. staffing, funding) for community coalitions

- Local and State: Actively solicit and use community input about MCH needs
- Local and State: Respond to community MCH concerns as they arise
- State: Provide funding and/or technical assistance for community-driven and generated initiatives and partnerships among public and/or private community stakeholders

Early Childhood System:

- Promote coordination and support for partner providers to a focus on the prevention and health promotion along a service continuum
- Improve communication and relationships within DHS and between DHS/OFH external early childhood partners
- Increase family and youth involvement in OFH policy and program design, development, implementation and evaluation
- Increase OFH facilitation, liaison and collaboration with public/private stakeholders
- Use the coordinated school health model as a base for expanded partnerships
- Actively work with child protective services such as multidisciplinary groups; provide more accessible data information; invite external partners to presentations/trainings; use technology more effectively
- Collaborate with stakeholders and partners on developing and improving a comprehensive, integrated approach to home visiting – starting before birth
- Increase local agency capacity through TA and needs assessment to improve collaborations with social services and parent education.

Local adolescent health: Need to collaborate or develop more partnerships with families and youth

 # 5 Leadership for policy development and advocacy

Public Health System:

- Local: Public health policy development
- Local: Community health improvement process
- State: Provide technical assistance and support to local public health systems and state partners to develop community health improvement plans, community development plans, and local operational plans
- State: Evaluate and review progress towards state-wide health improvement and policy impact
- State: Use information systems that provide useful data for policy development and planning

MCH System – not assessed

Early Childhood System:

- Synchronize policies and programs – using a client-centered philosophy, within our current partnerships within DHS
- Advocate for increased capacity of the child and family mental health service system to address both prevention and treatment.
- Advocate and promote universal developmental screening
- Ensure that issues of access and health disparities rise to the top and stay in the forefront of decision-makers at all levels (including the voting public & legislators), through OFH role to collect, analyze and disseminate data to all stakeholders and decision-makers

 # 6 Promote and enforce health policies

Public Health System:

- Local: Assessed as partially or adequately met
- State: Ensure administrative processes are customer-centered
- State: Evaluate and review technical assistance provided to local public health systems and state partners regarding enforcement
- State: Share system-wide resources to implement enforcement activities

MCH Systems- not assessed

Early Childhood System:

- Coordinate the regulatory and educational functions of public health with the Childcare Division.

 # 7 Link & assure access to services

Public Health System:

- Local: Identifying personal health services needs of populations
- Local: Assuring linkage of people to personal health services
- State: Work with health care providers to assure care for persons living in the state
- State: Incorporate perspectives of those who experience problems with accessibility and availability of health care
- State: Share system-wide resources to effectively provide needed personal services
- State: Use a workforce skilled in managing health services quality improvement programs

MCH System – not assessed

Early Childhood System:

- Integrate prevention and screening/early identification of risk conditions for mental health into public health settings
- Promote universal developmental screening
- Assure that children and parents have access to prevention, screening, diagnosis and treatment for mental health/social emotional development issus through partnership collaborations

- Increase access to care and reduce health disparities by including Information and Referral as an access to care issue (e.g., SafeNet-toll-free line); create linkages between existing health systems, formal/informal

#8: Workforce development

Public Health System:

- Local:
  - Public health leadership development
  - Workforce assessment
- State:
  - Assist in workforce development
  - Assure availability of educational courses to enhance workforce skills
  - Facilitate partner linkages to improve educational offerings
  - Evaluate and review workforce assessment activities
  - Assess achievements of workforce development plan
  - Use system of life-long learning for workforce
  - Use leadership development programs for statewide workforce
  - Use programs to develop cultural competencies among state wide and personal health services workforce

MCH System:

- Local: Support employees to promote cross-office, cross-disciplinary work and partnership building – as a critical job priority, not as an add-on to already full jobs

Early Childhood System:

- Provide education and resources on child health and development to social service workers and foster homes
- Assure that the public health workforce and other early childhood service providers are educated about mental health and social/emotional development, and trained to refer to mental health services.

Local Adolescent Health: No time or staff to adequately focus on adolescent health

 # 9 Evaluate effectiveness and quality of services

Public Health System:

- Local: Evaluation of population-based services and local public health system
- State: Provide technical assistance in evaluating performance of the Essential Public Health Services
- State: Offer consultation and guidance to conduct consumer satisfaction studies
- State: Review evaluation and quality improvement
- State: Manage current evaluation resources and develop new resources

MCH System:

- Local and state:
  - utilize data for quality improvement at the municipal and regional levels
  - Perform comparative analysis of programs and services
- State:
  - Support and/or assure routine monitoring and structured evaluations of state-funded services and programs
  - Provide and/or assure technical assistance to local health agencies in conducting evaluations
  - Provide resources for and/or collaborate with local health or other appropriate agencies in collecting and analyzing data on consumer satisfaction with services/programs and community perceptions of health needs, access issues, and quality of care
  - Disseminate information about the effectiveness, accessibility, and quality of personal health and population-based MCH services
  - Assume a leadership role in generating and disseminating information on private sector MCH outcomes

Early Childhood System:

- Promote increased use of information technology to improve multidisciplinary patient care, QI, and public health surveillance through medical/health care systems improvement, such as electronic medical records, "e-exchange' of data, child health profiles for use by providers

Local adolescent health: Evaluation and planning for adolescent health activities and services are underdeveloped or underutilized

#10 Support research and demonstrations

Public Health System:

- Local: Capacity for epidemiological, policy and service research
- State: Have and implement a public health research agenda
- State: Have a statewide communication process for sharing research findings on innovative public health practices
- State: Evaluate and review the state's ability to engage in public health research and communicate its findings
- State: Evaluate and review the ability to provide technical assistance with application and relevance of research findings
- State: Use findings from reviews to improve research activities

MCH System – not assessed

Early Childhood Systems – no comment

The table below shows the relationship between the Title V System framework and the general public health framework. The Oregon capacity assessment will be reported under Essential Services framework.

Relationship of Title V Pyramid of Services to Essential Public Health Services				
Title V Pyramid of Services: / **Essential Services of Public Health:**	**Direct:** Safety net services	**Enabling:** Support to access safety net services	**Population-Based:** Screening, outreach, population-based interventions	**Infrastructure:** Planning, assessment, Q.I./Q.A., data systems, training
# 1 Assess and monitor health status				*
# 2 Investigate health problems & hazards				*
# 3 Inform, educate and empower the public	*	*	*	*
# 4 Mobilize partnerships		*		*
# 5 Leadership for policy development & advocacy			*	*
# 6 Promote and enforce health policies			*	*
# 7 Link & assure access to services	*	*	*	*
# 8 Workforce development	*	*	*	*
# 9 Evaluate effectiveness & quality of services				*
#10 Support research & demonstrations			*	*

The summary below represents needs according to the 10 Essential Services

Health issues under consideration as part of the Office of Family Health 2004-2005 Needs Assessment											
	Insurance & Access to Care	**Mental/Emotional Health**	**Substance Abuse**	**Injury**	**Oral Health**	**Obesity/Nutrition**	**Disparity**	**Preventive & Screening**	**Reproductive**	**Chronic Disease**	**Other**
Pregnant Women	Prenatal Care in first 4 mo.	Perinatal depression	Tobacco & Alcohol		Oral Health Screening		Low Income Prenatal Care & Development and Delivery of Culturally and Linguistically Appropriate Svcs (Particularly for Hispanics)	Public Education Campaigns for Prevention of Maternal Risks and Conditions	Folic Acid Use & Unintended Pregnancy		
Women		Postpartum depression screening and referral		Domestic Violence & DVD and Sexual Assault					STD - Chlamydia		
Infants	Medical Home	Developmentally Appropriate Child Care & Social and Economic Influences on Behavioral Health					Black vs. White Infant Mortality	Hearing & Metabolic Screening & Developmentally Appropriate Child Care	Breastfeeding		
Children	Without Health Insurance & Access to Medical Home	Developmentally Appropriate Child Care & Social and Economic Influences on Behavioral Health		Child Abuse & Neglect, Auto and Unintentional Injury & Safekids Injury Prevention Program	3rd Graders with Sealants, EPSDT Rec'd Service & Oral Health Care Access & Dental Sealant Promotion and Education & Dental Sealants for School-age Children & Oral health Screening, Referral and Follow-up & Early Child Oral Screening & Follow-up	Childhood Obesity		Immunization & Car Seat Use & Developmentally Appropriate Child Care		Asthma	Capacity: Assessment and Planning for Community Needs and Gaps to Services
Adolescent	SBHC Access & School Based Health Centers & School Based Health Services	Depression/ Psychosis	Alcohol, Illicit Drugs, Tobacco & Alcohol, Drugs, Tobacco	Teen Suicide, Auto Accidents & Weapon Carrying		Childhood Obesity & Nutrition Promotion & Physical Activity Promotion		Comprehensive Screening & Coordinated School Health	Teen Pregnancy,Teen Birth Rate		
CSHCN	Adequate Insurance & Access to Medical Home	CSHCN Depression			CSHCN Oral Health	CSHCN Obesity					
OREGON POPULATION	Lack of Insurance & Providers not accepting OHP Clients & Medicaid	Mental Health Services	Tobacco & Alcohol & Drugs		Fluoridated Water & Lack of Dental Providers & Lack of Dental Insurance	Hunger		Resources for Prevention Education (Cancer, Injury)		Chronic Disease Interventions (Diabetes, CVD)	Communicable Disease (STD's, TB, Hep. C, Fecal-Oral) & Environmental Health (Indoor Air, Waste Disposal) & Geriatrics

Explanation:

•The top row of this grid is composed of cross-cutting major topics that impact the populations that the Office of Family Health (OFH) serves.

•The left most column is a list of the populations that the OFH serves.

•The blue health topics are topics on which DHS collects data as either an Oregon Benchmark or a Title V indicator.

•The grey or grey lined squares within the chart are health topics that were identified and recommended for consideration by Office of Family Health managers and staff. These topics may be in color because they were recommended in County Plans or because they are being tracked as a Title V or Oregon Benchmark indicator.

•Green health topics that are health priorities of CLHO-MCH.

•Red health topics were referred to in 6 or more 2004-2006 County Improvement Plans.

•Orange health topics are topics on which 20% or more of participating counties, requested assistance or information as part of the 2004-2006 Office of Family Health Plans.

HEALTH PRIORITY AIMS Appendix 9

Title V – Family Health

Draft

Category	AIM	Infant and Early Childhood	Middle Childhood	Adolescent	Women	CSHCN
Access	o Increase proportion of infants, children and adolescents who receive well-child/adolescent visits in the last 12 months. [1]T o Increase the number of integrated physical/mental health care sites utilized by adolescents. [2]					
Access	o Families report their child's health care needs are always met.[3]					
Access	o Families report that their out-of-pocket costs for their child's needs are always reasonable.[4]					
Access to Prevention	o Create access in all communities to a set of gold standard prevention services that will: ▪ Decrease infant mortality 20% ▪ Allow asthmatic children to breathe freely 90% of the time ▪ Insure children of all races ▪ Promise every pregnant woman access to early prenatal care. ▪ Reverse the financial disparity between prevention and treatment[5]					

HEALTH PRIORITY AIMS Appendix 9

Title V – Family Health

Draft

Category	AIM	Infant and Early Childhood	Middle Childhood	Adolescent	Women	CSHCN
Mental Health	o Improve children and adolescent mental health by increasing the percent of children who can—express and regulate feelings, form and maintain secure relationships, adapt to change, be "productive".[6]					
Mental Health	o Decrease by 50% of unaddressed social/emotional/mental health needs.[7] ▪ Screening and referral o Increase the percentage of the MCH population that reported that they had their mental health care needs met.[8]					
Prevention	o Increase the proportion of the MCH population who exhibit healthy lifestyle behaviors related to chronic disease prevention and management.[9] ▪ Increase breast feeding duration ▪ 5-A-Day consumption ▪ Physical activity ▪ Primary prevention through well-child visits					

HEALTH PRIORITY AIMS Appendix 9

Title V – Family Health

Draft

Category	AIM	Infant and Early Childhood	Middle Childhood	Adolescent	Women	CSHCN
Prevention	o Increase the sexual health of adolescents: ▪ Reduce the proportion of unintended pregnancy to meet 2010 benchmarks. ▪ Promote sexual health of adolescents to meet Oregon 2010 Health People Benchmark.[10]					
Protective	o Increase successes and engagement in school as a protective factor for children and adolescent health. (Success = feel like they can learn) [11]					
Protective	o Increase the proportion of children and adolescents that reported that they had an adult that they could depend on/ confide in.[12]					
Protective	o Parents report confidence in caring for their children.[13]					
Social/Ethnic	o Improve the MCH population's health status by decreasing the percent of individuals that live in poverty.[14]					
Social/ethnic	o Eliminate economic disparities to improve the overall health status of women.[15] Measures: ▪ Wage gap between men and women ▪ Household poverty					

Category	AIM	Infant and Early Childhood	Middle Childhood	Adolescent	Women	CSHCN
	Methods: ▪ Develop expertise on impact of economic disparities on health					
Social/ethnic	o Eliminate racial and ethnic disparities to improve health status.[16]					
Policy Advocacy	o Reduce morbidity and mortality of the MCH population through strong MCH leadership.[17] ▪ Every DHS policy that affects children and families will be modified to promote its positive impact on child health • Analyze current DHS policies for direct and indirect impact on child health. • Advocate within DHS to modify policies that have a negative impact on child health. • Sit at the table when new policies are developed. • Inclusion of child health status data in policy planning. • Inclusion of the impact of policy on child health as part of the Title V Needs Assessment.					

HEALTH PRIORITY AIMS Appendix 9

Title V – Family Health

Draft

Category	AIM	Infant and Early Childhood	Middle Childhood	Adolescent	Women	CSHCN
Policy Advocacy	o Increasing public health leadership to address the health care needs of people older than 65 years old. [18]					
Policy Advocacy	o Within five years policies will be in place to ensure healthcare coverage for all CSHCN.[19]					

[1] Adapted from the March 30, 2005 Title V Adolescent Health Prioritization Session. The Adolescent Health Prioritization Session was a pilot session. The three aims related to access to services issues were organized together under the topic "Access". The topic "Access" received the greatest number of votes resulting in the topic being ranked as the number 1 priority. The three aims were originally written as follows:

Access

- Increase the percentage of adolescents who reported that they had their mental health care needs met.
- Increase proportion of adolescent who receive well-adolescent visit in the last 12 months.
- Increase the number of integrated physical/mental health care sites utilized by adolescents.

[2] Adapted from the March 30, 2005 Title V Adolescent Health Prioritization Session. The Adolescent Health Prioritization Session was a pilot session. The three aims related to access to services issues were organized together under the topic "Access". The topic "Access" received the greatest number of votes resulting in the topic being ranked as the number 1 priority. The three aims were originally written as follows:

Access

- Increase the percentage of adolescents who reported that they had their mental health care needs met.
- Increase proportion of adolescent who receive well-adolescent visit in the last 12 months.
- Increase the number of integrated physical/mental health care sites utilized by adolescents.

[3] Adapted from the April 26, 2005 Title V Children with Special Health Care Needs Prioritization Session. This aim tied for the rank of 3 with one other aim from the session.

[4] Adapted from the April 26, 2005 Title V Children with Special Health Care Needs Prioritization Session. This aim tied for the rank of 3 with one other aim from the session.

[5] From the April 5, 2005 Title V Infant and Early Childhood Prioritization Session. This aim tied for the rank of 2 with 1 other aim from the session.

[6] Adapted from the April 11, 2005 Title V Middle Childhood Prioritization Session. Originally written as follows: Improve children's mental health by increasing the percent of children who can—express and regulate feelings, form and maintain secure relationships, adapt to change, be "productive". This aim received 5 votes and tied for the rank of 2 among other aims from the session.

[7] Adapted from the April 11, 2005 Title V Women's Health Prioritization Session. This aim tied for the rank of 3 with two other aims from the session.

[8] Adapted from the March 30, 2005 Title V Adolescent Health Prioritization Session. The Adolescent Health Prioritization Session was a pilot session. The three aims related to access to services issues were organized together under the topic "Access". The topic "Access" received the greatest number of votes resulting in the topic being ranked as the number 1 priority. The three aims were originally written as follows:
Access
- Increase the percentage of adolescents who reported that they had their mental health care needs met.
- Increase proportion of adolescent who receive well-adolescent visit in the last 12 months.
- Increase the number of integrated physical/mental health care sites utilized by adolescents.

[9] Adapted from the April 11, 2005 Title V Middle Childhood Prioritization Session. Originally written as follows: Increase the proportion of children in elementary school who exhibit healthy lifestyle behaviors related to chronic disease prevention and management. This aim received 5 votes and and tied for the rank of 2 among other aims from the session.

[10] Adapted from the March 30, 2005 Title V Adolescent Health Prioritization Session. The Adolescent Health Prioritization Session was a pilot session. Two aims related to sexual health were organized together under the topic "Sexual Health". This topic was ranked as the number 2 priority. The aims were originally written as follows: Sexual Health
- Reduce the proportion of unintended pregnancy to meet 2010 benchmarks.
- Promote sexual health of adolescents to meet Oregon 2010 Health People Benchmark.

[11] Adapted from the April 11, 2005 Title V Middle Childhood Prioritization Session. Originally written as follows: Increase successes and engagement in school as a protective factor for children's health. (Success = feel like they can learn). This aim received 5 votes and tied for the rank of 2 among other aims from the session.

[12] Adapted from the March 30, 2005 Title V Adolescent Health Prioritization Session. This aim was ranked as the number 3 priority. The aim was originally written as follows: Increase the proportion of adolescents that reported that they had an adult that they could depend on/ confide in.

[13] Adapted from the April 26, 2005 Title V Children with Special Health Care Needs Prioritization Session. Originally written as follows: Parents report confidence in caring for their children with special health care needs. This aim tied for the rank of 2.

[14] Adapted from the April 11, 2005 Title V Middle Childhood Prioritization Session. Originally written as follows: Improve children's health status by decreasing the percent of children that live in poverty. This aim received 6 votes and tied for the rank of 1 among other aims from the session.

[15] Adapted from the April 11, 2005 Title V Women's Health Prioritization Session. This aim received the rank of 1 among other aims from the session.

[16] Adapted from the April 11, 2005 Title V Women's Health Prioritization Session. This aim received the rank of 2 among other aims from the session.

[17] Adapted from the April 5, 2005 Title V Infant and Early Childhood Prioritization Session. Originally written as follows: Improve morbidity and mortality of the 0-5 population through strong MCH leadership. This aim received 20 votes and ranked number 1 among other aims from the session.

[18] Adapted from the April 11, 2005 Title V Women's Health Prioritization Session. This aim received the rank of 3 among other aims from the session.

[19] From the April 26, 2005 Title V Children with Special Health Care Needs Prioritization Session. This aim received the rank of 1.

AIM: Families report their child health care needs are always met.

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Children 0-5	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights	Community asset mapping – Health Watch communities Support Quality Assurance Require well-child visits	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of providers and health plan staff Educate parents	Health plans, providers, OMAP, child care, tribal health agencies, schools, child care, faith organizations	
Children 6-9	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights School based health centers	Community asset mapping – Health Watch communities Support Quality Assurance Require well-child visits	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of providers and health plan staff Educate parents	Health plans, providers, OMAP, child care, tribal health agencies, schools, faith organizations	
Adolescents 10-24	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights School based health centers	Community asset mapping – Health Watch communities Support Quality Assurance Require well-child adolescent visits	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of providers and health plan staff Educate parents and adolescents	Health plans, providers, OMAP, child care, tribal health agencies, schools, faith organizations	
CYSHN	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights	Community asset mapping – Health Watch communities Support Quality Assurance Require well-child visits	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of providers and health plan staff Educate parents	Health plans, providers, OMAP, child care, tribal health agencies, schools, faith organizations	
Women	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights	Community asset mapping – Health Watch communities Support Quality Assurance	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of providers and health plan staff	Health plans, providers, OMAP, child care, tribal health agencies, schools, faith organizations	
Pregnant Women	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights	Community asset mapping – Health Watch communities Support Quality Assurance Require well-child visits	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of	Health plans, providers, OMAP, child care, tribal health agencies, schools, faith organizations	

	Interventions	Public Health Systems	Capacity Building	Partners	Other
			providers and health plan staff Educate parents		
Other Populations: Rural/Underserved	Universal health coverage Expand benefits to include all needed preventive services Improve family and individual knowledge of health care benefits and rights	Community asset mapping – Health Watch communities Support Quality Assurance Require well-child visits	Advocate for issues identified in ?? health care .?? child health measure report Training of Title V on managed advocacy Address training issues of providers and health plan staff Solve Internet connectivity in rural areas Issues for rural MDs, hospitals, health departments, expand access to specialists through telehealth	Health plans, providers, OMAP, child care, tribal health agencies, schools, faith organizations	

Draft 1, 5/9/05: Jim Gaudino, Molly Emmons, Bob Nickel, Bob Nystrom, Claudia Bingham.

AIM: The maternal and child health population exhibit healthy lifestyles.

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Children 0-5	Physical activity promotion Promote regular check ups, including oral health Establish healthy feeding relationships Breastfeeding promotion	Continue to build relationships with community partners Breastfeeding friendly birthing facilities	Develop and communicate information with community partners Build, improve, and sustain FamilyNet data system and data warehouse Analyze and provide information in a way that groups and partners can identify with	Lelech League Medical care and other providers Hospitals, Non-profits, special interest groups, major manufactures, media, insurance/MCOs/DCOs, faith groups Child care Schools Parents	
Children 6-9	Physical activity promotion Promote regular check ups, including oral health Establish healthy feeding relationships Promote good school food choices Health education to identify issues and choices	Continue to build relationships with community partners School health programs Make school physical activity programs inclusive, not exclusive	Develop and communicate information with community partners Build, improve, and sustain FamilyNet data system and data warehouse Analyze and provide information in a way that groups and partners can identify with	Medical care and other providers Hospitals, Non-profits, special interest groups, major manufactures, media, insurance/MCOs/DCOs, faith groups Child care Schools Parents	
Adolescents 10-24	Physical activity promotion Promote regular check ups, including oral health Establish healthy feeding relationships Smoking prevention Promote good school food choices Health education to identify issues and choices	Continue to build relationships with community partners School health programs Make school physical activity programs inclusive, not exclusive	Develop and communicate information with community partners Analyze and provide information in a way that groups and partners can identify with	Medical care and other providers Hospitals, Non-profits, special interest groups, major manufactures, media, insurance/MCOs/DCOs, faith groups Child care Schools Parents	
CYSHN	Respite care Transitional needs	Continue to build relationships with community partners School health programs	Develop and communicate information with community partners Build, improve, and sustain FamilyNet data system and data warehouse Analyze and provide information in a way that groups and partners can identify with	Medical care and other providers Hospitals, Non-profits, special interest groups, major manufactures, media, insurance/MCOs/DCOs, faith groups Child care Schools Parents	

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Women	Physical activity promotion Promote regular check ups, including oral health Establish healthy feeding relationships Breastfeeding promotion	Continue to build relationships with community partners School health programs	Develop and communicate information with community partners Build, improve, and sustain FamilyNet data system and data warehouse Analyze and provide information in a way that groups and partners can identify with	Medical care and other providers Hospitals, Non-profits, special interest groups, major manufactures, media, insurance/MCOs/DCOs, faith groups Child care Schools Parents	
Pregnant Women	Physical activity promotion Promote regular check ups, including oral health Establish healthy feeding relationships Breastfeeding promotion	Continue to build relationships with community partners	Develop and communicate information with community partners Build, improve, and sustain FamilyNet data system and data warehouse Analyze and provide information in a way that groups and partners can identify with	Medical care and other providers Hospitals, Non-profits, special interest groups, major manufactures, media, insurance/MCOs/DCOs, faith groups Child care Schools Parents	
Other Populations					

Draft 1, 5/9/05: Sherry Spence, Sue Woodbury

AIM: Improve children and adolescent mental health by increasing the percent of children who can express and regulate feelings, form and maintain relationships, adapt to change, and be productive.

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Children 0-5	Provide MH consultation for child care providers Identify 0-2 hi-risk using David Olds home visit/nurse partnerships and social development assessment model		Train MH consultants to work with county public health Build strong families	Head Start Parents Families Child Care Div OMHAS Resource & Referral	
Children 6-9	Promote implementation of new school health standards Promote positive youth development	Healthy Kids Learn Better model		Schools Families	
Adolescents 10-24	Promote implementation of new school health standards Promote positive youth development	Healthy Kids Learn Better model			
CYSHN			Assess transitional needs		
Women					FAS prevention
Pregnant Women					
Other Populations					

Draft 1, 5/9/05: Claudia Bingham, Molly Emmons, Bob Nystrom, Jim Gaudino, Bob Nickel

AIM: Eliminate racial and ethnic disparities to improve health status.

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Children 0-5	Leaders must make addressing health disparities a priority. 1st step is to assess which disparities to focus on in Oregon (see Surgeon General's report) Staff training in areas such as participatory community assessment. Creation of and accountability to an advisory board. Increase the number of health professionals from under represented groups (Annual Data Report Assoc. of Schools of Public Health; HP 2010 B-1-18) OFH staff attending community meetings. Increase in the percent of public health professionals, physicians and nurses who speak languages in addition to English.	Answer the question: "What does it mean to do community level work when you are a state employee?" Incorporate the answer into public health systems.		Office of Multicultural Health, Coalitions, Non-profits, advocacy groups, churches, schools, clubs, insurance companies, community clinics	1st step is to assess which disparities to focus on in Oregon (see Surgeon General's report)
Children 6-9					
Adolescents 10-24					
CYSHN					
Women					
Pregnant Women					
Other Populations					

Draft 1, 5/9/05: Isabelle Barbour, Eve Pepos, Julie McFarlane.

AIM: Parents report confidence in caring for their children.

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Children 0-5	Promote pediatric/medical home provider education Education and advocacy for programs, policies, benefits that promote health [developmental, health benchmarks, policy guidance] Promote participatory action and collaborative models like Healthy Start Develop planning, feedback, evaluation systems that engage and include "full circle" families, providers and service organizations	Identify natural communication networks and utilize them for grandparents, grand kids Connect with organization, agencies, groups, where target populations are	Involve youth Involve peers and support systems Involve families Park systems, churches, businesses, community centers, daycare centers, laundromats, apt. complexes, law enforcement, juvenile justice systems Share information for best practice, strategies, and resources or lack of both with families and organizations that work with children, youth and families Find a way/tools for identifying resources for children, youth, and their families: "who you gonna call" in each community	Early intervention Head Start OCCF City, County, State agencies Statewide non profits Community non profits Faith community SafeNet Toll Free line	
Children 6-9	Promote pediatric/medical home provider education Education and advocacy for programs, policies, benefits that promote health [developmental, health benchmarks, policy guidance] Promote participatory action and collaborative models like Healthy Start Develop planning, feedback, evaluation systems that engage and include "full circle" families, providers and service organizations	Identify natural communication networks and utilize them for grandparents, grand kids Connect with organization, agencies, groups, where target populations are	Involve youth Involve peers and support systems Involve families Park systems, churches, businesses, community centers, daycare centers, laundromats, apt. complexes, law enforcement, juvenile justice systems Share information for best practice, strategies, and resources or lack of both with families and organizations that work with children, youth and families Find a way/tools for identifying resources for children, youth, and their families: "who you gonna call" in each community	Youth Schools School based health centers City, County, State agencies Statewide non profits Community non profits Faith community	
Adolescents 10-24	Promote pediatric/medical home provider education Education and advocacy for programs, policies, benefits that promote health [developmental, health benchmarks, policy guidance] Promote participatory action and collaborative models like Healthy Start	Identify natural communication networks and utilize them for grandparents, grand kids Connect with organization, agencies, groups, where target populations are	Involve youth Involve peers and support systems Involve families Park systems, churches, businesses, community centers, daycare centers, laundromats, apt. complexes, law enforcement, juvenile justice systems Share information for best practice, strategies, and resources	Youth Schools School based health centers City, County, State agencies Statewide non profits Community non profits Faith community	

	Interventions	Public Health Systems	Capacity Building	Partners	Other
	Develop planning, feedback, evaluation systems that engage and include "full circle" families, providers and service organizations		or lack of both with families and organizations that work with children, youth and families Find a way/tools for identifying resources for children, youth, and their families: "who you gonna call" in each community		
CYSHN	Promote pediatric/medical home provider education Education and advocacy for programs, policies, benefits that promote health [developmental, health benchmarks, policy guidance] Promote participatory action and collaborative models like Healthy Start Develop planning, feedback, evaluation systems that engage and include "full circle" families, providers and service organizations	Identify natural communication networks and utilize them for grandparents, grand kids Connect with organization, agencies, groups, where target populations are	Involve youth Involve peers and support systems Involve families Park systems, churches, businesses, community centers, daycare centers, laundromats, apt. complexes, law enforcement, juvenile justice systems Share information for best practice, strategies, and resources or lack of both with families and organizations that work with children, youth and families Find a way/tools for identifying resources for children, youth, and their families: "who you gonna call" in each community	CDRC Family Voices OFSN, NAMI, DD Coalitions OCCF City, County, State agencies Statewide non profits Community non profits Faith community	
Women					
Pregnant Women		Identify natural communication networks and utilize them for grandparents, grand kids Connect with organization, agencies, groups, where target populations are	Involve peers and support systems Involve families Park systems, churches, businesses, community centers, daycare centers, laundromats, apt. complexes, law enforcement, juvenile justice systems Share information for best practice, strategies, and resources or lack of both with families and organizations that work with children, youth and families Find a way/tools for identifying resources for children, youth, and their families: "who you gonna call" in each community	City, County, State agencies Statewide non profits Community non profits Faith community	
Other Populations					

Draft 1, 5/9/05: Becky Adelmann, Ruth Helsley, Jane Fouste.

AIM: Reduce morbidity and mortality of the MCH population through strong MCH Leadership.

	Interventions	Public Health Systems	Capacity Building	Partners	Other
Children 0-5 Children 6-9 Adolescents 10-24 CYSHN Women Pregnant Women Other Populations	Build a coalition to impact policy change Evidence-based practice Specific priorities based on evidence	Analyze DHS policies for direct and indirect impact on child health Add health impact statement to legislative bill analysis	Develop PHAB's role in advocacy Enlist PH directors to elevate advocacy role for public health Transform our data into information that can be used for policy advocacy; get the data into the hands of the people who can use it Strategize with partners about how to move the agenda	Health plans Non-profit agencies Early childhood partners CLHO Tribes Families	FamilyNet Data System

Draft 1, 5/9/05: Nurit Fischler, Katherine Bradley.